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**THE ASSOCIATION BETWEEN PARENTAL PERCEPTIONS OF CHILDREN'S  
RESIDENTIAL MENTAL HEALTH TREATMENT AND THE PARENT-CHILD  
RELATIONSHIP**

by

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## ABSTRACT

THE ASSOCIATION BETWEEN PARENTAL PERCEPTIONS OF CHILDREN'S  
RESIDENTIAL MENTAL HEALTH TREATMENT AND THE PARENT-CHILD  
RELATIONSHIP

Susanne Elizabeth Preston

Old Dominion University, 2010

Chair: Dr. Danica Hays

Residential mental health treatment for children as an intervention for children is increasing, potentially affecting the relationship within families. The purpose of this study was to examine the parental perspectives of the associations between the parent-child relationship and children's residential mental health treatment. This study explored parental perspectives of specific aspects of the parent-child relationship: parental support, satisfaction with parenting, parental involvement, communication, and limit setting-and the association between these aspects and the child's residential mental health treatment. Paired samples *t*-tests were conducted; resulting in statistically significant changes on all scales measured, with varying effect sizes. Results indicated parents perceived significantly less discord in the parent-child relationship and significantly greater levels of: support, satisfaction with parenting, involvement, positive communication, and limit setting in the parent-child relationship after the child participated in treatment, as compared to before the child participated in treatment. Further, the lived experience of a parent having a child participating in residential mental health treatment was investigated through a focus group interview. The themes that

emerged from the data were: Parental Involvement, Help for the Family, and Help for the Child.



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## **CHAPTER ONE**

### **STATEMENT OF THE PROBLEM**

Between 10% and 20% of children (over 7.5 million) have a mental health problem, with a small percentage having a severe mental illness (Rethink, 2009). The number of children with behavioral problems has been continuously increasing over the last two decades (Kelleher, McInerney, Gerdner, Childs, & Wasserman, 2000). Children are being identified with behavioral problems at an earlier age (Keenan & Wakschlad, 2000). Common examples of behavioral problems include: aggression, delinquency, withdrawal, social problems, somatic problems, defiance, theft, destruction to property, lying, running away from home, and sexual acting out behaviors (Morrison & Anders, 1999). Children are receiving suspensions and even expulsions at school, while defying parents and even becoming aggressive toward them in the home.

A serious mental health condition is present in one out of every ten children in the U.S. (U.S. Public Health Service, 2000). Accordingly, A report by the National Mental Health Information Center detailed that common diagnoses of children that have been diagnosed with a mental illness are: attention deficit disorder (36.5%), mood disorder (31.8%), oppositional defiant disorder (26.6%), adjustment disorder (12.9%), conduct disorder (11.7%), post-traumatic stress disorder (8.6%), substance use (7.6%), V-code (5.7%), disruptive behavior disorder (5.3%), learning and related disorder (5.2%) impulse control disorder (5.2%), anxiety disorder (4.2%), mental retardation (3.7%), psychosis (2.2%) and autism and related disorder (1.9%) (SAMHSA's National Mental Health Information Center, 1999). Problems such as Attention Deficit Hyperactivity Disorder

and Oppositional Defiant Disorder are commonly diagnosed in young children now. Exploring children's residential mental health treatment may provide strategies for treatment interventions that could be utilized in residential treatment. Exploring the parent-child relationship within that treatment, due to the impact of it on children's mental health and on treatment, also may provide strategies for treatment interventions.

### **Background**

The quality of family functioning has been shown to be important for a child's psychological well being and physical health (Sanders, 1999). A good quality parent-child relationship that involves high quality interactions, including children sending clear cues about their needs and wants and parents being sensitive and responding to those needs, fosters children's successful development and resilience (Letourneau et al., 2009). Further, poor quality interactions among parents and children may lead to developmental problems and mental health issues (Letourneau, Drummond, Fleming, Kysela, McDonald, & Stewart, 2001).

Further, previous studies suggest a strong association between the parent-child relationship and children's mental health. For example, Conner and Rueter (2006) found that maternal warmth predicted adolescent suicidal tendencies. Harach and Kuczynski (2005) found that parental overuse of power and authority, or even temporary non-responsiveness, can damage the parent-child relationship.

Additionally, Lakin, Brambila, and Sigda (2004) found that children whose parents were more involved in their residential treatment showed lower rates of recidivism and that children in families with higher levels of parental involvement in their residential treatment showed better family functioning and less functional

impairment. These findings imply that there is an association with children with stronger familial relationships and their treatment outcomes. There is limited research exploring the association between treatment and relationship. Therefore, the study will add to the literature and look at changes in that perceived relationship after the treatment period.

### **Residential Mental Health Treatment**

Residential mental health treatment centers often incorporate family interventions that aim to improve the strength of the parent–child relationship and restore family functioning. One assumption is that parents or guardians are primary agents for children succeeding in treatment (Baumrind, 1995; Collins, Maccoby, Steinberg, Hetherington & Bornstein, 2000; Steinberg, 2001). For this reason, many residential treatment centers are making the transition to more family centered models of treatment (Zielinski & Bradshaw, 2006).

Although the primary treatment model for children with behavioral and emotional disorders is outpatient therapy (Northey, Wells, Silverman, & Bailey, 2003) with approximately 5% to 10% of children and their families utilizing outpatient counseling services (Northey et al., 2003), children and families must be matched to the appropriate level of services that may include residential treatment (Northey et al., 2003).

Residential treatment is designed to be more intensive than outpatient treatment. Outpatient treatment usually consists of a client attending hour long counseling sessions once a week or bi-weekly for about 8 to 12 sessions (AARC, 1999). Residential treatment typically lasts at least 3 months while the child resides at the treatment facility and engages in therapeutic activities throughout the day.

Residential treatment programs are also the costliest and most intensive forms of care that are offered to children with behavioral and emotional disorders, other than inpatient psychiatric care (James, et. al, 2006). Research has found that treatment for longer periods is associated with more positive outcomes. On average, treatment for a minimum of three months has been related with more positive outcomes (Burdon, Dang, Prendergast, Messina, & Farabee, 2007). In some cases, such as substance abuse treatment, this means less incidence of relapse (Burdon et al., 2007). When more intense treatment plans are adopted, research demonstrates that patients start to express more positive feelings (Burdon et al., 2007). Individuals who were in residential treatment receiving consistent one-on-one attention were more likely to indicate a better sense of overall satisfaction in regards to treatment than individuals in outpatient treatment (Burdon et al., 2007). Equally important, residential treatment programs serve children and adolescents who first failed in other treatment programs. It is often regarded as a treatment of last resort (Frensch & Cameron, 2004; Trout, Hagaman, Chmelka, Gehringer, Epstein, & Reid, 2008).

Studies show that parent-child relationship quality was associated with well-being (Podjamy, 2007; Frensch & Cameron, 2004). The parent-child relationship appears to be critical in the development of the child, with or without a disorder. This study investigated the constructs of parental support and will examine parental perceptions of the parent-child relationship in detail.

Lastly, Pumariega (2006) stated there is a national crisis on how the residential treatment level of care is implemented in the field. Specifically, Pumariega stated that the imperatives for cost reduction in state child welfare, juvenile justice, and mental health

programs, as well as the lack of focus in developing community-based interagency alternatives, have resulted in placing children with mental health needs into residential treatment program facilities. Foltz (2004) reported that more research about residential treatment and its effectiveness for children is needed. Foltz points out treatment providers need more data that will help them become aware of the best treatment.

### **Purpose Statement**

The increasing number of children diagnosed with mental illnesses and the importance of the parent-child relationship to children's mental health and to their treatment prompted the need to investigate the parent-child relationship in relation to the residential treatment provided to children with mental illness. Empirical studies related to the research problem have been limited to examining the topics of children's residential treatment or parent-child relationships separately. This study examined the areas of children's residential mental health treatment and the parent-child relationship combined. In addition, a qualitative focus group interview was utilized in order to further examine the topics in depth. Qualitative studies are able to go deeper into the subject matter, and examine it more closely. Therefore, this study combined quantitative instruments and added a qualitative component for in-depth examination of the topic. A concurrent explanatory design was employed, as the majority of the study is quantitative, with a smaller qualitative portion added to address one of the research questions.

This mixed methods study also examined parental perceptions of the parent-child relationship. A quantitative methodology was utilized to examine parental responses to scales asking them about their parent-child relationship at the beginning and end of their

child's residential mental health treatment. Also, a qualitative methodology was utilized to examine parental responses during a group interview about the parent-child relationship during their child's residential mental health treatment. Using a social constructivist paradigm and phenomenological tradition, the qualitative portion of the study examined the experience of parents who have a child receiving residential mental health treatment, specifically examining the parent-child relationship within that experience.

Thus, this study explored residential mental health treatment for children and its relationship with multiple factors associated with the parent-child relationship, including parental support, parental involvement, communication, limit setting and satisfaction with parenting. The Parent-Child Relationship Inventory (Gerard, 1994) and the Index of Parental Attitudes (Hudson, 1993) instruments were used to measure how parents viewed the task of parenting, how they felt about their children, and the severity of problems in the parent-child relationship as seen by the parents. A group interview with parents of children who are currently receiving residential mental health treatment was also conducted to explore their perceptions of the parent-child relationship. Understanding how residential treatment for children's mental health issues is associated with the parent-child relationship helps inform understanding of how residential mental health treatment benefits the family, and thus may help us create residential programs that help restore family functioning more effectively. Ultimately, this might influence children's mental health, due to better family functioning.

## **Research Questions**

The primary research question that this study investigated is: Is there a significant change in the parent-child relationship for children ages 5-13 years old with emotional and behavioral disorders who have received residential treatment? The following specific research questions will be examined during this study:

- 1) Is there a significant change in perceptions of the parent-child relationship, as measured by the Index of Parental Attitudes, from pre to post-residential treatment for parents of children ages 5 to 13 with emotional and behavioral disorders?
- 2) Is there a significant change in perceptions of the parent-child relationship, as measured by the Parent-Child Relationship Inventory scales, from pre to post-residential treatment for parents of children ages 5 to 13 with behavioral and emotional disorders?
  - Is there a significant change in the level of support a parent perceives is present, as measured by the Parental Support scale of the PCRI completed by the parents of children ages 5-13 with behavioral and emotional disorders from pre to post-residential treatment?
  - Is there a significant change in the degree of satisfaction with parenting that a parent perceives is present in the parent-child relationship, as measured by the Satisfaction with Parenting scale of the PCRI completed by the parents of children ages 5-13 with behavioral and emotional disorders from pre to post-residential treatment?

- Is there a significant change in the amount of parental involvement that a parent perceives is present in their parent-child relationship, as measured by the Parental Involvement scale of the PCRI completed by the parents of children ages 5-13 with behavioral and emotional disorders from pre to post-residential treatment?
  - Is there a significant change in the communication in a parent child relationship, as measured by the Communication scale of the PCRI completed by the parents of children ages 5-13 with behavioral and emotional disorders from pre to post-residential treatment?
  - Is there a significant change in the limit setting by a parent in a parent-child relationship, as measured by the Limit Setting scale of the PCRI completed by the parents of children ages 5-13 with behavioral and emotional disorders from pre to post-residential treatment?
  - 3) What is the essence of the experience for parents who have a child in residential mental health treatment? How do parents perceive it to affect the parent-child relationship?
- 3) The two research questions in number 3 correspond to the qualitative portion of the research design.

### **Key Concepts and Key Constructs**

#### **Residential Treatment**

The terms “residential treatment center” and residential treatment are used herein to refer to short or long-term residential programs for children and adolescents with



mental health issues. This definition does not encompass other forms of residential programs, such as juvenile justice facilities.

The American Association of Children's Residential Centers defines a residential treatment center as:

An organization whose primary purpose is the provision of individually planned programs of mental health treatment, other than acute inpatient care, in conjunction with residential care for seriously emotionally disturbed children and youth, ages 17 and younger. It has a clinical program within the organization that is directed by a psychiatrist, psychologist, social worker, or psychiatric nurse... (AARTC, 1999).

### **Parent**

Another important construct for this study is the construct of a parent. For the purpose of this study, the term "parent" refers to a child's mother, father, stepmother, stepfather, grandmother, grandfather, guardian, or other caregiver residing with the child and acting in the parenting role.

### **Parent-Child Relationship**

The parent - child relationship is also an important term to define for this study. Researchers (Lezin, Roller, Bean, & Taylor, 2004) have argued that a positive parent-child relationship creates an "emotional climate" of affection, warmth, satisfaction, trust, and minimal conflict (defined by some researchers as "cohesion") (p. 7). In a positive parent-child relationship, parents and children enjoy spending time together, communicate freely and openly, support and respect one another, share similar values,

and have a sense of optimism about the future. This package of desirable family attributes also has been called “family strengths” (Moore, 1993).

Conversely, in a negative parent-child relationship, the emotional climate is harsher. Instead of affection, parents and children experience hostility and anger, sometimes to the point of violence (either directly or as witnesses). Unresolved conflict is high between parents and between parents and children. Communication, understanding, and respect are absent. Instead of mutual attachment, there is something more akin to mutual detachment. However, this is not an either or dichotomy. Parent-child relationships can fall somewhere in the middle, having some positive relationship characteristics and some negative relationship characteristics.

### **Parental Involvement**

The construct of parental involvement was also examined in the research study. For the purpose of this study, parental involvement is a parent’s interaction with his or her child and a parent’s knowledge of his or her child (Gerard, 2005). According to the National PTA, “Parental involvement is the participation of parents in every facet of the education and development of children from birth to adulthood, recognizing that parents are the primary influence in their children's lives” (Green, 2002, p. 1).

Accordingly, decades of research by National PTA have demonstrated that the more involved parents are in their children's development, the greater chance children have to succeed, particularly in their academic performance. Consistently, researchers have discovered that greater parental involvement in a child's education is associated with: higher student grades and test scores, better attendance, higher rates of homework completion, higher graduation rates, greater enrollment rates in post-secondary education,

and most notable for this study- more positive student attitudes and behavior (Green, 2002). When parents are involved, children achieve more regardless of their socioeconomic level, ethnic/racial background, or the parents' educational level (Henderson & Berla, 1994).

### **Satisfaction with Parenting**

Satisfaction with Parenting was another construct measured in this study. It is the amount of pleasure and the amount of fulfillment an individual derives from being a parent (Gerard, 2005). Satisfaction with parenting is closely related to parenting self-efficacy. A burgeoning area of research on parenting has concentrated on parenting self-efficacy, defined as parents' perceptions of their ability to influence the behavior and development of their children. Previous research (Young, Karraker, & Cottrell, 2006) has shown that parents with higher self-efficacy are themselves more satisfied with parenting.

### **Communication**

Communication is a construct that was measured in the research study as part of the parent child relationship. Communication was measured through assessing a parent's perception of how effectively he or she communicates with his or her child (Gerard, 2005). Communication scholars have closely studied family communication as a more specific and important part of the discipline of communication. During the 1990s, researchers identified that families have distinctive characteristics that are not paralleled in other types of interpersonal communication (Whitchurch & Webb, 1995). Because of these characteristics, family communication must be approached differently than other types of interpersonal communications. The impact of family life on children has been

well documented, and communication experts look at this as a product of interpersonal communication throughout childhood (Vangelisti, 1993).

One expert, Virginia Satir, defined communication as the giving and receiving of information between two people (Satir, 1987). Satir believed that healthy communication between people is congruent communication. When communication is congruent, connecting energy is present and clear communication is achieved (Satir, 1987). Human communication can also be defined as the process of exchanging information and ideas. It is an active process that involves encoding, transmitting, and decoding the intended message (Owens, 1986).

Further, communication can be examined from the following viewpoints (Littlejohn, & Foss, 2008). Mechanistic Communication is a perfect transaction of a message from the sender to the receiver. Psychological Communication is the act of sending a message to a receiver, and the feelings and thoughts of the receiver upon interpreting the message. Social Constructionist Communication is another way to view communication, as the product of the interactants sharing and creating meaning. Systemic Communication is the new message created via “through-put”, or what happens as the message is being interpreted and re-interpreted as it travels through people. Finally, Critical Communication is a source of power and oppression of individuals and social groups. Considering communication from these alternate viewpoints can be helpful in gaining an understanding parent-child communications in general and the needs of the child in particular. This is related to this research because communication is one of the main constructs that will be tested to see if parents perceive it to be improved after residential treatment.

**Limit Setting**

Limit setting is also a construct that was studied in this research. Parents were asked to rate items that focus on their perceptions of their experiences disciplining their child (Gerard, 2005). Gorney (1994) explained the integration of personal limits, as well as an increasing awareness of the limits of others are both established during childhood and adolescence with the help of parents. According to Webster-Stratton and Dahl (1995), when parents display inconsistent limit-setting with their children, it typically results in behavior problems in their children. For these reasons, many residential programs incorporate parenting classes with a major focus on teaching parents how to set limits, into the program curriculum (Neale & Rosenheck, 2000). Therefore, limit setting is a construct that was examined in the study.

**Parental Support**

Parental support is an important construct that was studied in this research. For this study, parental support refers to the emotional and social support that a parent receives (Gerard, 2005). One component of many residential treatment centers is an intervention designed to support the parent while the child receives treatment. By the time children's behaviors problems have evolved to a level in which residential treatment is being initiated, most parents are overwhelmed and in need of support. Stressors such as difficulty accepting and adjusting to their child's disability, financial demands for necessary medical care, limited (or no) accessible information about their child's disability, time management conflicts, and appropriate respite care and other services to relieve their caretaking activities are burdens that parents have to handle (Ainbinder, 1998).

Mechanisms of support assist parents to improve the quality of the parent-child relationship, develop realistic expectations for their child's development, and reduce family stress (Dinnebeil, 1999; Mahoney & Kaiser, 1999). Parental support interventions include information, advice, guidance and parent education. These aim to strengthen skills and promote knowledge of parents to provide their children with developmental enhancing learning opportunities (Dunst, 1999). More optimal parenting behavior is associated with informal and formal social support for parents (Torquati, 2002). Informal support includes giving indirect advice and knowledge sharing while formal social support includes establishing a structure that would ensure parents support. Various activities offered to parents tend to lessen the stress in having a child with needs (Dinnebeil, 1999; Mahoney & Kaiser, 1999).

### **Emotional Disorder**

The construct of an emotional disorder is defined for this research study. An emotional disorder is any mental disorder not caused by detectable organic abnormalities of the brain and in which a major disturbance of emotions is present (Houghton Mifflin, 2002). It has also been defined as: an emotional, and/or social impairment exhibited by a child or adolescent that consequently disrupts the child's or adolescent's academic and/or developmental progress, family, and/or interpersonal relationships (McGraw-Hill, 2002). Mood disorders and Anxiety disorders are examples of emotional disorders.

### **Behavioral Disorder**

A final construct examined in this research study is a behavioral disorder. A behavioral disorder is a disorder characterized by displayed behaviors over a long period of time which significantly deviate from socially acceptable norms for a person's age and

situation (McGraw-Hill, 2002). A second definition is: Any of various forms of behavior that are considered inappropriate by members of the social group to which an individual belongs (Houghton Mifflin, 2002). Examples of behavioral disorders include: Oppositional Defiant Disorder, Impulse Control Disorder, and Conduct Disorder.

### **Summary**

In summary, the parent-child relationship may be a significant construct in children's residential mental health treatment. Children whose parents were more involved in their residential treatment showed lower rates of recidivism and children in families with higher levels of parental involvement in their residential treatment showed better family functioning and less functional impairment (Lakin, Brambila, & Sigda, 2004). Similarly, parental overuse of power and authority, or even temporary non-responsiveness can damage the parent-child relationship (Harach & Kuczynski, 2005). This chapter provided the rationale and theoretical underpinnings for the study. It presented parent-child relationship, residential treatment, parental involvement, satisfaction with parenting, communication, limit setting, parental support, parental attachment style, emotional disorders, and behavioral disorders as factors considered in the study.

## CHAPTER TWO

### REVIEW OF THE LITERATURE

This review divides the relevant literature into seven parts: general examination of the parent-child relationship, including attachment in childhood; the parent-child relationships and mental health; the etiology and statistics of children's mental health issues; components of residential treatment; the effectiveness of children's residential treatment; challenges of residential treatment; and the use of parent-child relationship questionnaires. They will be examined throughout this chapter to provide information explaining the need for this research and how it will fill in gaps in the current literature.

Literature on child and adolescent mental health treatment has historically been limited and is "rife with methodological problems so that existing studies are generally inconclusive" (Mann-Feder, 1996, p. 1). In particular, Mann-Feder noted that literature examining residential treatment success for adolescents has been dominated by pessimism, which has provided little useful information for clinical practice. Criteria for outcome success have been poorly defined and, due to lack of standardization or use of global indices, the data has yielded little meaningful information. Moreover, the sparse empirical work has meant that the literature has historically been dominated by theorizing rather than clinical research (Mann-Feder, 1996). Recent literature (Foltz, 2004) has been more comprehensive, but still lacks any exploration into the relationship between residential treatment programs and parent-child relationships.

Some researchers (e.g., McNeil & Herschell, 2005) have shown that children's behaviors, notably non-compliance and aggression, are associated with the parent-child relationship in negative ways. It has been shown that a positive parent-child relationship



is associated with positive parental well-being, and that a negative parent-child relationship is associated with adolescent's suicide risks (Connor & Rueter, 2006). Researchers also have examined the psychometric properties of the Parent-Child Relationship Inventory (Coffman, Guerin, & Gottfried, 2006) and have compared the use of relationship questionnaires to behavioral observations for measuring and assessing parent-child relationship quality (Janssens, DeBruyn, Manders, & Scholte, 2006).

### **Parent-Child Relationships**

The parent-child relationship was examined in this study. The parent-child relationship is arguably the most important relationship we form over the course of the life span (Steinberg, 2001). Studies of child development are paying more attention to the parent-child relationship, in order to understand how it develops and functions over the lifespan. Researchers are examining many questions that concern normative changes in the parent-child relationship over the course of development (Steinberg, 2001). The impact of variations in the parent-child relationship on the child's behavior and functioning is being studied in research such as the impact of authoritative parenting in longitudinal studies (Steinberg, Lamborn, Darling, Mounts & Dornbusch, 1994).

There are two elements of the parent-child relationship, attachment and play, which are associated with peer competence (Kathryn & Joan, 1995). Although not related to one another, linkages have been found between (a) attachment security and physical play interactions in mother-child and father-child dyads and (b) between these parenting components and peer competence (Kathryn & Joan, 1995).

The quality of the parent-child relationship is particularly important in understanding the course of a child's development. The parent-child relationship is

influenced by contextual factors such as the child's birth order, the child's temperament, parental financial stress, parental emotional stress, gender of the parent, social support of the parent, and the parent's personality (Bornstein, 2002). Parents of first born children engage with them more often and express affection toward them more often than they do to their later born children (Bornstein, 2002). According to Price (2008) in his study using data from the American Time Use Survey, a first-born child receives 20-30 more minutes of quality time each day with his or her parent than a second-born child of the same age from a similar family. It was also found that unemployment, which causes psychological and economic stress, is frequent in neglectful families (Child Welfare Information Gateway, 2010). Consequently, parents under financial and emotional stress are less sensitive and attentive to their children than parents not under stress, which affects the parent-child relationship in negative ways (Bornstein, 2002). Mothers with good social support are less punitive and restrictive with their children than mothers without that support (Bornstein, 2002). Levels of parental psychopathology are also related to the quality of the parent-child relationship and child adjustment (Bornstein, 2002).

### **Parental Support**

Parental Support was also a variable examined in this study. Ainbinder et al. 1998 examined the establishment of support systems of and for the parents of children with special needs. It found that the system became a reliable ally for supporting parents due to perceived sameness, situational comparisons that enable learning and growth, round-the-clock availability of support, and mutuality of support. Empirical evidence shows that a parent-to-parent support system creates a community of similar others

trained to listen and be supportive and provides an opportunity for matched parents to experience equality and mutuality in their relationship (Ainbinder et al., 1998). Similarly, Jeynes (2005) stressed that “programs which support parents influenced educational outcomes although at a lesser degree compared to the preexisting expressions of parental support” (p. 76). Because of this influence, Jeynes (2005) suggests that schools should consider adopting strategies to enhance parental engagement in their programs.

Confronting difficulties in parenting children with special needs is well researched (Breslau, Staruch, & Mortimer, 1982; Diehl, Moffit, & Wade, 1991; Gallagher, Beckman, & Cross, 1983; Singer, Irvin, & Hawkins, 1988). Stressors such as difficulty accepting and adjusting to their child's disability, financial demands for necessary medical equipment and care, limited accessible information about their child's disability, time management conflicts, and appropriate respite care and other services to relieve their caretaking activities are associated with parents losing interest in helping with the challenges of their children.

### **Satisfaction with Parenting**

Satisfaction with Parenting is another variable that was examined in this research. Satisfaction with parenting is the amount of pleasure and the amount of fulfillment an individual derives from being a parent Gerard (2005). Satisfaction with parenting is closely related to parenting self-efficacy, defined as parents' perceptions of their ability to influence the behavior and development of their children. Previous research (Young, Karraker, & Cottrell, 2006) has shown that parents with higher self-efficacy are themselves more satisfied with parenting. Thus, the association with parenting self-efficacy further substantiates the need for assessing satisfaction with parenting.

Self-efficacy, however, is not static since the element of time and other factors may contribute to self-efficacy. William (2002), in a study that examines parenting and parents' involvement across time, illustrated that as children got older, parents lost confidence in their ability to help. Also, parents may have wanted to be involved or to heighten their level of involvement in their parenting role, but felt that time limitation was the barrier that obstructed their efficacy as parents.

Parental socio-economic status (SES) significantly affects the involvement of the parents with their children. Williams et al. (2002) implied that working class parents suffered great challenges in terms of attending to the needs of their children. Nevertheless, Hoover-Dempsey and Sandler (1997) concluded that parents see parenting and their involvement as part of their role or 'job'. Hence, determining parents' views on the importance of parenting is a key factor which underpins attribution of responsibility. However, how parents define their role as parents, with regard to providing the best parental involvement to their children, are very complex due to factors like ethnic and sub-cultural differences (Hoover-Dempsey & Sandler, 1997; Nechyba et al., 1999; Sacker, 2002).

Parental role construction is not the only determinant of parents' involvement. Their 'sense of personal efficacy' is also implicated (Hoover-Dempsey & Sandler, 1997). This refers to the degree to which one feels able to make a difference. This in turn depends on a number of related beliefs, attitudes and skills (Hoover-Dempsey & Sandler, 1997). Desforges (2003) reported when children have the innate ability to achieve, it takes little effort from them to get their parents' involvement. Significantly, Hoover-Dempsey and Sandler (1997) argued that beliefs and competences are distributed as

individual differences amongst parents. These researchers added that those who have ‘can do’ attitudes and beliefs that personal efforts create abilities will, at least potentially, be at the forefront in parental involvement. Those parents who hold contrary beliefs might be expected to be fatalistic about their child’s educational progress (Hoover-Dempsey & Sandler, 1997).

### **Parent-Child Communication**

Parent-Child Communication was also a variable examined in this study. The parent-child relationship is mutually accommodating and based on reciprocity. The healthy parent-child micro system produces a positive emotional climate as the quality of interactions and nurturance is high and expectation realistic, creating developmental opportunity for the child (Garbarino & Abramowitz, 1992). In that this style of parenting provides a balance between control and independence, it is likely to produce a child who is competent, socially responsible, self-assured, and independent (Gonzalez-Mena, 1993). It is in this positive emotional climate that the child can develop high self-esteem and a positive self-concept. One way in which the relationship is reciprocal is through communication. The quality of interactions can also be largely based on communication, which can express nurturance and expectations. Through expressions in a quality interaction, a positive emotional climate can be created to help a child develop a positive self concept and high self esteem.

Thus, according to Smith (1998), effective parenting is built on communication and planned, ongoing communication is the crucial missing link in many families. As parents are the major influence in the child’s life, optimum development in early childhood is thus largely dependent on the parent’s knowledge of how children think and

learn. Gable (2010) reports research suggests that the most favorable parent-child relationships are characterized by a great amount of positive communication and interaction. According to Gable (2010), when parents stay connected with children through attention and conversation, children may be less likely to misbehave. Effective communication is a two-way social interaction. Therefore, it is not only important to understand the impact of parental understanding of child development but also the mechanisms the child utilizes to understand what the parent is communicating to them (Yahaya, 2006). Children learn about ways of communicating in personal relationships through utilizing patterns of interactions among family members as a model (Yahaya, 2006).

Sound parent-child relationships are based on effective communication that is friendly and respectful in manner (Balson, 1994; Smith, 1998). Parents should communicate with their child either by sitting low or kneeling, utilizing positive responses such as smiles and interest, and by concentrating or paying attention to the child's activity (Balson, 1994; Smith, 1998). Balson (1994) also claimed that effective communication between parents and children is a two-way process involving listening and expressing. To listen effectively, that parent needs to give the child their undivided attentions, notice the child's feelings and the words used and actively attend to what is being conveyed. Grisdale, Cater and Morton-Evans, as cited by Wong (2008), identified some examples of effective listening, such as watching body language, making "being heard" gestures and waiting for the child to finish talking before saying anything.

Understanding communication in the context of child-parent relationship requires understanding social influence in families, particularly parents' socialization practices.

Hoffman (1980) asserted that parenting practices are the determinant in predicting children internalization of family values and norms. Maccoby and Martin (1983) linked the family as the primary site of socialization towards the broader interpersonal norms. These researchers added that modeling and discipline coupled with punishment and reward systems help children internalize the norms of the family (Maccoby & Martin, 1983). Stafford (2004) suggested that parents' own behavior shapes the children's development of social competencies. Consequently, Teti, Douglas, Candelaria, and Margo (2002) suggested that modeling functional behavior is the primary goal of parenting. Competent parenting should be determined in terms of achieving the socialization desired for the children.

### **Limit Setting**

Limit Setting was a variable examined in this study. Limit setting, according to Jones's Positive Discipline model, is any actions that are taken to control natural reflexes of learners to prompt them to appropriate on-task behavior through the use of body language (Jones, 2005). Limit setting can reduce the likelihood of confrontations and can deal with high frequency misbehaviors quickly and effectively (Romano, 2005). Dawson and Clark (1998) discussed that without healthy limits children feel wary and insecure. They could become reckless and uncaring about their welfare. Dawson and Clark (1998) added that setting limits that are too strict can be unhealthy as well. If parents set limits that are too restricting, children will over-adapt and become passive, or demand attention with rebellious behavior. When healthy limits are set for them, children learn gradually to set their own limits, and to value themselves. Healthy limiting setting builds self-esteem. This way, children get stimulation and recognition in safe and healthy ways.

In a similar manner, Rothenberg (2008) emphasized that children need limits. When these limits are not excessive, they make children feel better and feel secure due to their conforming behavior. Howard (2002) supported this and posited that love and approval of the parents are one of the basic principles in limit setting that parents must understand. Howard (2002) stressed that the need for love prompts children to respond and meet parents' expectations provided that the parents keep the expectations consistent, reasonable, and predictable. This way, limit setting is effective and can help the child gain control over his or her behavior (Howard, 2002).

However, limit setting had been criticized to be intrusive and disruptive to the entirety of the learning outcomes (Wolfgang, 2001). Wolfgang (2001) concluded that limit setting does not allow for verbal communication between the learner and the teacher. As a result, the teacher is not able to express how the misbehavior makes him or her feel. Limit setting is a short-term fix that does not address the cause of the problem or help students to become better people (Wolfgang, 2001). Despite this view, this construct will be researched in this study because, whether it is effective or disruptive to learning outcomes or not, it is still used by parents as a way to control children's behaviors and manage conflict in families.

### **Parental Involvement**

Parental Involvement was also examined in this study. As previously stated, when parents are involved, children achieve more regardless of their socioeconomic level, ethnic/racial background, or the parents' educational level (Henderson & Berla, 1994). Henderson and Berla (1994)'s findings, however, were contested with research that shows relationships between children's development and their environment



(Nechyba et al., 1999). Parental involvement and its impact on the child's development, however, are dependent on several factors (Desforges, 2003). Family, size, structure, income and employment pattern have all been implicated as bearing on educational achievement and personal adjustment (Desforges, 2003). Data on parental involvement on the development of the child and positive outcomes must be interpreted with the clear recognition that these processes will be influenced by a wide range of other factors and at the same time will work through a range of intervening processes.

Sacker et al. (2002) concluded that social class had a strong relationship to parental involvement. The higher the social class, the more parental involvement was evident (Sacker et al., 2002). Desforges (2003), however, concluded that relationship between parental involvement and achievement is probably not linear which means that doubling parental involvement will not double achievement and that it is proactive as well as reactive. Parents take the level of interest and involvement appropriate to the scene as they see it (Desforges, 2003).

Research on parental involvement in the literature focuses on their involvement in the children's school rather than mental health treatment, and outcomes are measured by academic achievements. Sui-Chu and Williams (1996) examined the extent of parents' involvement and its influence to educational achievement and the degree to which parental involvement was associated with different family backgrounds in terms of ethnicity and social class. The study revealed that research on parents' home involvement has been limited to home discussion and home supervision while parents' school involvement have been limited to school communication and participation only.

Seemingly, parental involvement encompasses a wide range of activities that motivate the child to perform their expected activities towards expected outcomes.

Desforges (2003) reported that parents can display different types of involvement, including: parenting, communicating, volunteering, teaching at home, decision making, and collaborating with the community. As shown above, involvement by parents helps children to achieve. This study measured parental involvement in a variety of contexts, other than the child's academic achievement.

### **The Nature, Function, and Dynamics of Attachment in Childhood**

Attachment may be a component of factors impacting the parent-child relationship. In order to understand the parent-child relationship, one must first examine attachment in childhood. Bowlby (1969, 1982) observed that in general infants require the care and protection of adults in order to survive. Adopting ideas from control theory, Bowlby argued that the attachment system has the set goal of maintaining proximity to one or a few individuals. When these individuals, or attachment figures, are perceived as available and responsive, the infant feels secure and explores the environment confidently but continues to maintain contact in subtle ways (e.g., with brief glances or intermittent vocalizations). In contrast, when a child is not certain about an attachment figure's availability, the child experiences anxiety and attempts to maintain or reestablish contact by protesting. The child may cry, search for the attachment figure, follow the attachment figure, or cling to the attachment figure. According to Bowlby, these attachment behaviors are adaptive because they help to reestablish proximity to an absent attachment figure or prevent an attachment figure from leaving.

Another factor contributing to the organization of attachment behavior is the duration of the attachment relationship or, a related variable, the age of the child. Research indicates that older children are less distressed by maternal separation than are younger children (Blehar, 1974; Maccoby & Feldman, 1972). According to Bowlby (1969, 1973, 1982), there are at least two reasons for this. First, children's representational capacities become more sophisticated over time. Thus, older children are better able to infer the reasons for and the likely duration of the separation. Second, as the attachment relationship evolves, children and their caregivers develop what Bowlby called a goal-corrected partnership. Through repeated experiences, children and caregivers explicitly or implicitly negotiate the parameters of their relationship and regulate their behavior on the basis of mutual goals and needs. Thus, older children learn that separations, when they occur, will be brief, and that the caregiver will eventually return.

One of the most widely studied variables known to influence the organization of attachment behavior is attachment style, a set of knowledge structures or working models representing the responsiveness and availability of attachment figures. According to Bowlby (1969, 1982), these representations help to shape and constrain attachment behavior by providing expectations about how the attachment figure is likely to respond in particular situations.

Research on children indicates that individual differences in these working models vary along two dimensions: Avoidance and Anxiety (Ainsworth et al., 1978; Brennan, Clark, & Shaver, 1998). The first dimension, Avoidance, captures variability in the tendency to feel uncomfortable with closeness or dependence. The second dimension,

Anxiety, reflects a fear of abandonment. Children classified as secure occupy the lower ends of these two theoretical dimensions. These children appear to be confident about the availability and responsiveness of the caregiver and actively seek contact with him or her when distressed. Children classified as avoidant are high in Avoidance and low in Anxiety (Brennan et al., 1998). They are unlikely to seek the care and comfort of the attachment figure when they are distressed (Ainsworth et al., 1978). Furthermore, they are likely to value their own autonomy and independence rather than relying on attachment figures as a secure base (Cassidy, 1988). Anxious-ambivalent children are high in Anxiety and low in Avoidance (see Brennan et al., 1998). They tend to exhibit heightened attachment-related concerns and vigilantly monitor the whereabouts of their caregivers. When separated from their attachment figures, they exhibit intense attachment behavior, often protesting vigorously for an extended period. When reunited with a missing attachment figure, they exhibit a mixture of angry resistance and desire for comfort. Research indicates that variability in the way working models are organized (i.e., whether a child feels uncomfortable with closeness or worries about being abandoned) depends at least in part on prior experiences with caregivers (Ainsworth et al., 1978). Thus, children who are secure or comfortable with closeness are more likely than avoidant children to have had responsive and sensitive care giving (Ainsworth et al., 1978; Main & Weston, 1982).

In summary, research on children indicates that the way attachment behavior is organized in a particular situation depends on several factors, including physical accessibility of the attachment figure, duration of the attachment relationship, and working models of attachment. Theoretically, each of these factors plays a role in

determining whether the child judges the attachment figure to be accessible or inaccessible, and, hence, whether the set goal of proximity is exceeded or not.

Developmental problems and mental health issues that vulnerable children experience may be influenced by the quality of interaction that they had with their parents as infants (Letourneau, Drummond, Fleming, Kysela, McDonald, & Stewart, 2001).

Maternal behaviors such as: unresponsiveness, insensitivity to the child's cues, impatience, less verbal interaction, and less responsiveness to the child, threaten a child's mental health (Letourneau et al., 2001). Mothers in parent-child relationships with attachment problems often show these behaviors. However, high quality, mutual social interactions between a parent and a child in which a parent responds to children's needs promotes healthy social interactions that facilitate a child's successful development (Letourneau et al., 2001).

### **Attachment Behavior Theory**

The attachment behavior system is an important concept in attachment theory because it provides the conceptual linkage between ethological models of human development and modern theories of emotion regulation and personality. According to Bowlby, the attachment system essentially "asks" the following fundamental question: Is the attachment figure nearby, accessible, and attentive? If the child perceives the answer to this question to be "yes," he or she feels loved, secure, and confident, and, behaviorally, is likely to explore his or her environment, play with others, and be sociable. If, however, the child perceives the answer to this question to be "no," the child experiences anxiety and, behaviorally, is likely to exhibit attachment behaviors ranging from simple visual searching on the low extreme to active following and vocal signaling

on the other. These behaviors continue until either the child is able to reestablish a desirable level of physical or psychological proximity to the attachment figure, or until the child "wears down," as may happen in the context of a prolonged separation or loss. In such cases of helplessness, Bowlby believed the child experiences despair and depression (Fraley & Shaver, 2000).

Harach and Kuczynski (2005) urge researchers to consider different domains that co-exist and mutually influence each other within the parent-child relationship. They examined emerging ideas about the complexity of parent-child relationships. It has been assumed that the parent-child relationship is bidirectional, or a joint product of parent and child actions (Patterson, 1982, as cited in Harach & Kuczynski). In their study, parents reported children's behavior, which exhibited responses over a strengthened, damaged, and repaired relationship. Misused or overuse of authority and being non-responsive to the child's attachment needs were reported to caused damage to the parent-child relationship. Residential treatment is often used as a last resort, and parents have often by the time of treatment damaged the relationship by misusing or overusing their authority in attempts to gain control of the child.

Parents reported children created the tension in the relationship most often by not complying with parental requests, or by being coercive. Patterson (1982, as cited in Harach and Kuczynski, 2005) also found noncompliance as an aversive behavior that is damaging to the parent-child relationship. Conversely, parents in this study reported that their children were most likely to strengthen the parent-child relationship by complying with parent requests and engaging in companionate interactions, whereas not complying or challenging parent directives created relational tension.

O'Connor, Dunn, Jenkins, and Rasbash (2005) studied the parent-child relationship variance within families (why a parent develops a more supportive relationship with one child compared to a sibling in the same family) and between family variance. They reported that some of the most robust explanations for why parents treat children differently focus on negative behaviors. They found that within family variation was largely accounted for by child specific factors, most notably aggressive behavior.

Attachment is an important topic to discuss as a foundation for this research because attachment theory is an important part of the parent-child relationship and this study is examining the parent-child relationship. Further, when children enter residential treatment, they are often living away from their parents for months at a time, which arguably could affect their level of attachment, or their level of attachment with their parents could affect their treatment.

### **Parent-Child Relationships and Mental Health**

This study examined the relationship between mental health treatment and the parent child relationship. Mental health is an important influence on parenting and the parent-child relationship (Torquati, 2002). Mental health is also affected greatly by the parent-child relationship. Examples of effects of parental behaviors and psychopathology on children's mental health follow. Parenting behaviors have been linked consistently with the well-being of children and with children's developmental outcomes (Baumrind, 1995; Collins, Maccoby, Steinberg, Hetherington & Bornstein, 2000; Steinberg, 2001). The quality of parenting affects a child's adjustment (Zielinski & Bradshaw, 2006). The practices of parents who maltreat their children are more authoritarian than the parenting practices of parents who do not maltreat their children (Baumrind, 1995). Parental

psychopathology has been found repeatedly to negatively influence the quality of parenting (Rutter & Quinton, 1985). A parent's mental illness has great potential to disrupt the care giving process (Zielinski & Bradshaw, 2006). Parents that have severe psychiatric problems or alcohol and drug abuse problems are less able to take care of their children's needs, as they experience difficulties taking care of their own needs (Bolger, Thomas, & Eckenrode, 1997; Zielinski & Bradshaw, 2006). Children exhibit more prosocial behaviors when their parents provide positive, non-coercive discipline and have positive feelings toward their children (Knafo & Plomin, 2006).

As a foundation of examining parent-child relationships by the parental perspective, the general closeness of parents and children in their relationships with each other across the country needs to be discussed. The National Survey of Children's Health (NSCH) asked parents to assess their closeness with their children. Most of the parents (87 percent) reported being very close to their children. A greater percentage of parents of 6-year-olds (96 percent) reported being very close to their children than parents of 17-year-olds (76 percent). Still, for the most part, parents and children maintained close bonds, with three-quarters of these relationships described as very close, even when the child was 17 (Moore, Guzman, Hair, Lippman & Garret, 2004). Parents who lived with their children (ages 6-17), most reported feeling very close to their children, even as they grew into adolescence (87 percent). Thirteen percent of parents reported that they were just "somewhat close" to their children. Less than 1% of parents reported that their relationship was "not very close".

Research studies on family-centered intervention note that family-focused services for affected children is effective as system-of-care (SAMHSA's National Mental



Health Information Center, 1999). This system has the view that engaging families in therapy sessions with their children is more beneficial than only treating the child, because parents can be involved to help the therapist to identify the known strengths of the child and to identify what avenues of support are available or needed for each child. SAMHSA's National Mental Health Information Center (1999) further noted that in a community-based rating of system-of-care principles, family focused therapy ranked first highest followed by collaborative or coordinated efforts. Psychologists believe that the family-focused system is effective (Center for Mental Health Services, 2003). As the family focused system-of-care is effective and shown to be beneficial, this research will examine children's residential mental health treatment that involves several different components of family involvement.

### **Etiology and Statistics of Children's Mental Health Issues**

The current literature was reviewed in order to determine a need for residential mental health treatment and research further exploring it. Critical emotional and mental health conditions are valid medical conditions (U.S. Department of Health and Human Services, 1999). One in 10 children is affected by a serious mental health condition and only one third of them receive any care (U.S. Public Health Service, 2000). Nearly 50% of the individuals who have a serious mental health condition during their lifetime report that the onset of problem occurred by age 14 years and three fourths report that the onset of the problem occurred by age 24 years (Ronald, Patricia, Olga, Robert, Kathleen & Ellen, 2005). Nearly half of the students with a mental health condition 14 years or older drop out of school, the highest dropout rate for any disability group (U.S. Department of Education, 2001). Approximately 1 in 5 children in the U.S. exhibit signs and symptoms

of a DSM-IV disorder during the course of a year (Northey, Wells, Silverman, & Bailey, 2003). About 5% of children suffer from a mental disorder that causes extreme functional impairment (Northey et al., 2003).

The Diagnostic and Statistical Manual of Mental Disorders IV-Text Revised (APA, 2000) lists the following categories of disorders usually diagnosed in infancy, childhood, or adolescence: mental retardation, learning disorders, motor skills disorders, communication disorders, pervasive developmental disorders, attention deficit and disruptive behavior disorders, feeding and eating disorders, tic disorders, and elimination disorders (APA, 2000). Children can be diagnosed with disorders from other categories from the manual; however, these are the categories of diagnoses of which children most often present (APA, 2000). The attention deficit and disruptive behavior disorders are the category most commonly seen in children treated in residential centers. This category is made up of the diagnoses: Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, Conduct Disorder, Attention Deficit Hyperactivity Disorder Not Otherwise Specified, and Disruptive Behavior Disorder Not Otherwise Specified (APA, 2000).

Attention Deficit Hyperactivity Disorder is characterized by symptoms of inattention, hyperactivity, and impulsivity (Morrison & Anders, 1999). Subtypes are offered for labeling the most prominent symptom (APA, 2000). The family members of children with Attention Deficit Hyperactivity Disorder have a high prevalence of Mood Disorders, Anxiety Disorders, Learning Disorders, and Antisocial Personality Disorders (APA, 2000). There is a strong influence of genetic factors on levels of hyperactivity, impulsivity, and inattention. However, school, peer, and family factors are crucial in determining the extent of the symptom levels (APA, 2000). About half of children with

Attention Deficit Hyperactivity Disorder also have Oppositional Defiant Disorder or Conduct Disorder (APA, 2000). Low birth weight, a history of abuse or neglect, multiple foster placements, neurotoxin exposure, drug exposure in utero, Mental Retardation, and infections are associated with Attention Deficit Hyperactivity Disorder (APA, 2000). Attention Deficit Hyperactivity Disorder is also associated with low frustration tolerance, temper outbursts, bossiness, mood lability, insistence that needs be met, poor self esteem, rejection by peers, stubbornness, and dysphoria (Morrison & Anders, 1999).

Oppositional Defiant Disorder is characterized by a pattern of defiant, hostile, and negativistic behavior (APA, 2000). Oppositional Defiant Disorder appears to be more common in families in which at least one parent has a history of a Mood Disorder, Oppositional Defiant Disorder, Conduct Disorder, Attention Deficit Hyperactivity Disorder, Substance Related Disorder, or Antisocial Personality Disorder (APA, 2000). The number of oppositional symptoms often increases with age. It is more prevalent in males before puberty, but equal to females after puberty. Associated features include: low self-esteem, mood liability, low frustration tolerance, swearing, and use of alcohol and drugs (APA, 2000). It is common for children with Oppositional Defiant Disorder to also have an Attention Deficit Hyperactivity Disorder, Learning Disorders, or Communication Disorders (Morrison & Anders, 1999).

Conduct Disorder is more severe than Oppositional Defiant Disorder and is characterized by a pattern of behaviors that violate society's norms or major age-appropriate rules, as well as the basic rights of others (APA, 2000). Conduct Disorder is more common in males. It is influenced by both genetic and environmental factors. It appears to be more common in families where at least one parent has a history of

Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, a Mood Disorder, Substance Related Disorder, Conduct Disorder, or an Antisocial Personality Disorder (APA, 2000). Conduct Disorder is associated with the early onset of drinking, using illegal substances, smoking, sexual activity, recklessness, and risk-taking behaviors. Conduct disorder may be associated with lower than average intelligence, especially a lower verbal IQ. Conduct disorder may also be associated with: Learning Disorders, Anxiety Disorders, Mood Disorders, and Substance Related Disorders (APA, 2000). An individual may be predisposed to develop conduct disorder under these circumstances: parental rejection and neglect, difficult infant temperament, peer rejection, large family size, harsh discipline, inconsistent child rearing practices, lack of supervision, early institutional living, physical or sexual abuse, frequent changes in caregivers, association with a delinquent peer group, maternal smoking during pregnancy, neighborhood exposure to violence, and familial psychopathology including Substance Abuse or Dependence and Antisocial Personality Disorder.

Mental disorders and mental health problems appear in families of all social classes and of all backgrounds. Children who are at greatest risk have physical problems; intellectual disabilities (retardation); low birth weight; family history of mental and addictive disorders; multigenerational poverty; and caregiver separation or abuse and neglect. A range of efficacious psychosocial and pharmacologic treatments exists for many mental disorders in children, including attention-deficit/hyperactive disorder, depression, and the disruptive disorders (Surgeon General's Report, 1999).

Emotional and behavioral disorders in childhood are often connected to the parents. For example, behavior problems in children have been found to be correlated

with harsh and negative discipline practices by parents (Prinz, Onghena, Hellinckx, Grietens, Ghesquiere, & Colpin, 2004). Researchers (Wakschlag & Hans, 1999; Wendland-Carro, Piccinini, & Millar, 1999) have demonstrated the need to enhance the quality of early interactions between children and their parents in order to reduce developmental problems and mental health issues in children.

Childhood disorders can be connected to family relationships. For example, Connor and Rueter (2006) report that risk for adolescent suicide includes both individual and family factors. They studied how these factors place adolescents at risk for suicide, or protect them from it. They stated that parental behaviors such as warm or hostile parenting are important in identifying risk and protective factors for suicide. They also stated that negative or hostile parenting characteristics are related to subsequent adolescent emotional distress and suicide. They found that positive behaviors on the parents' part can protect an adolescent from later suicidality. They state that support received from parents should be seen as playing a vital role in the outlook of each adolescent's life. This shows the importance for research to examine the parent-child relationship for problems and to further examine the level of parental support in the relationship.

Johnson, Cohen, Kasen, Smailes and Brooks (2001) found that maladaptive parental behavior is associated with parental and offspring psychiatric symptoms. Maladaptive parental behavior was associated with an increased offspring risk for psychiatric disorders in adolescence and early adulthood (Johnson, Cohen, Kasen, Smailes, & Brook, 2001). These researchers concluded that maladaptive behavior is an important factor between parental and offspring psychiatric symptoms. Further, Kopp and

Beauchine (2007) found that comorbid conduct problems and depression are significantly associated with parental psychopathology, including anti-social behavior and depression (Kopp & Beauchine, 2007). Kopp and Beauchine (2007, p. 310) noted, “Parental psychopathology contributes to and is affected by child behavior over time”. Since this research is showing that parental behaviors affect a child’s mental health, then it makes sense to get parents involved in the child’s mental health treatment so they can learn ways to better help their children.

Studies show a link between parents and child aggression. Barnow, Lucht and Freyberger (2004) tested a model for aggressive and delinquent conduct problems in adolescence. They found a significant relationship between adolescent aggressive and delinquent behavioral problems and parental antisocial behavior; perceived parental warmth and self-esteem. They concluded that only intervention methods that include parents and peers may help decrease the incidence of aggressive and delinquent behavior in adolescents.

### **Components of Residential Treatment**

Literature on residential treatment was reviewed in order to further determine gaps in the research that needed to be filled. A residential treatment center is an organization with the primary purpose of providing mental health treatment and residential care to seriously emotionally disturbed youth under the guidance of a psychiatric professional (AARC, 1999). Several components are required to make up a residential treatment center: a therapeutic milieu, a multidisciplinary care team, deliberate client supervision, intense staff supervision and training, and consistent clinical/administrative oversight (Butler & McPherson, 2006). Children that need intense

interpersonal services need a collaborative team of professionals to treat them from a bio-psycho-social perspective (Butler & McPherson, 2006). Careful client supervision must be provided at all times due to the client diagnoses and behaviors, and senior administrative guidance and training must be provided to support the treatment staff.

Residential facilities provide intensive therapeutic services for children. These community-based institutions are composed of teams of psychologist, psychiatrist, family therapists, social workers, special educators, counselors, and nurses. They conduct sessions for patients while a multi-disciplinary team addresses all needs as well as draft the treatment plan. They conduct family therapy sessions to create an opportunity for families to heal and change; rehearse new behaviors; and have conferences for parents.

Residential treatment denotes the extended stay facilities with intensive services, often focused at a specific population. Residential treatment is less intensive than inpatient facilities such as hospitals as the treatment is longer term. Patients admitted at residential facilities usually have rules and regulations that facilitate the safety of patients and promote their movement towards independence. Residential treatment ranges from a few weeks to several months. There are many children who participate in residential treatment for mental health needs each year, which requires them to be separated from their families for extended periods of time. The number of children treated in residential facilities and the length of treatment time is increasing and will continue to increase in the future (U.S. Department of Health and Human Services, 1999).

### **Effectiveness of Children's Residential Treatment**

Residential treatment programs serve children and adolescents who tend to first fail in other treatment programs. It is often regarded as a treatment of last resort (Frensch

& Cameron, 2004; Trout, Hagaman, Chmelka, Gehringer, Epstein, & Reid, 2008). Families utilize residential treatment services after many other services have been ineffective.

Frensch and Cameron (2004) conducted a review of studies of residential treatment effectiveness delivered in group home settings and residential treatment centers and concluded that, despite methodological shortcomings and variability in programming, residential services did improve functioning for some, but not all, youth. Improved functioning was noted in the areas of improved psychological adjustment, improved school performance, reduction in the mean criminal offense rate, improved peer relationship skills to an adequate level, and improved interaction skills with authority to an adequate level or higher. These researchers noted that treatment gains were not easily maintained and dissipated over time. This exemplifies why it is important to study the area of children's residential mental health treatment further so that effective treatments can be identified.

During the residential treatment care, children gain greatly and are spared much trauma. Children avoid abuse, neglect, and the stressors of chaotic families, truancy and hospitalizations decrease, and medication management is provided (Butler & McPherson, 2006). Frensch and Cameron (2004) found that the level of family involvement in treatment was predictive of post-treatment adjustment. Successful post-treatment adjustment also depended on post-treatment environmental factors such as available support and residential stability. This research study will specifically examine the constructs of parental support and parental involvement as it relates to the post-treatment adjustment of children in a residential treatment center.



Placement in residential care mainly aims to provide a safe living environment that can protect youth from his or her dangerous behavior, protect others from a youth's dangerous behavior, or facilitate the treatment of the youth's emotional or behavioral problems (Wells & Whittington, 1993; Whittaker, 2004; Whittaker & Pfeiffer, 1994). Residential treatment is widely regarded as a necessary placement option in any comprehensive continuum of care, however it is relatively restrictive and expensive (Burns et al., 1999; Farmer et al., 2004; Lyons, 2004). For these reasons, it is problematic that some researchers claim its effectiveness has not been clearly specified (Burns et al., 1999; Farmer et al., 2004; Lyons, 2004). This research potentially will add to the literature about treatment effectiveness by providing specific information regarding residential treatment and its associations with the parent-child relationship.

Nickerson, Colby, Brooks, Rickert and Salamone (2007) studied the relationship between residential mental health program outcomes and transition planning for discharge. They found that systematic transition planning through family involvement, service coordination, and community involvement is critical for achieving change for youth with emotional and behavioral disorders in residential treatment centers. They interviewed staff, parents and adolescents regarding these practices, and found that the results indicated that although the specific residential treatment program involved adolescents and parents in discharge planning, taught youth skills for success in the community, and facilitated community involvement, other areas needed improvement, such as communication between the residence and the adolescents' home schools, more frequent and longer home visits, and aftercare services (Nickerson et al., 2007). These findings suggest that successful residential treatment involves parental and community

interaction. If involvement of the parent is required for the residential treatment to be successful, this points to the need for research to examine the parent's relationship with the child, and how that is associated with residential treatment.

Bates, English, and Kouidou-Giles, (1997) summarized the research literature on residential treatment and the alternative interventions of family preservation services. They found that research examining the differences between youth in residential facilities versus less restrictive forms of treatment has yielded mixed results due to a lack of uniform diagnostic criteria for placement in residential and other treatment settings, and because placement decisions may be based more on availability than on an actual assessment of the need for the level of treatment. This points to the need for examination of diagnostic information regarding children admitted for residential treatment.

Parental involvement is a specific construct that was be examined in this study. It has been found to be important by other researchers. For example, Brown and Greenbaum (1994) found that any gains made during a stay in residential treatment quickly disappear upon discharge, creating a cycle where children return again and again to residential treatment centers. They claim one of the reasons why residential treatment centers fail to deliver the results they promise is the lack of family involvement (Brown & Greenbaum, 1994). This points to the need to further examine family involvement, or parental involvement in order identify potential ways to involving families in treatment at residential centers.

Many studies are more optimistic about the effectiveness of residential treatment. Leichtman et al. (2001) studied 123 adolescents with severe psychiatric problems and reported that intensive, short-term residential treatment resulted in a clinically substantial

improvement from admission to discharge, and improvement was sustained for the year following discharge. Also, Lyons et al. (2001) found that residential treatment is effective at reducing high risk behaviors and psychotic symptoms but may exacerbate anxiety and hyperactivity. However, residential treatment has not been found to result in better clinical outcomes than community-based treatment for children with mental disorders (Barth, 2002).

Johnson, Kent, and Leather (2005) stated studies indicate that interventions designed to strengthen the parent-child relationship are efficacious in alleviating behavioral disorders. They also cite a problem with most studies done in the area of parent-child relationships as being cross-sectional and only correlational, leading to problems of interpretation. The above research shows the potential positive outcomes and effectiveness for children receiving residential treatment services. It also shows the need for further research to examine residential treatment and its associations with the family more clearly in order to better establish its effectiveness.

### **Challenges of Residential Treatment**

There are many challenges inherent in residential treatment for children. According to Butler and McPherson (2006, p.3), "Various types of residential treatment intervention models present a complex, multivariate and methodological challenge." Although the many of the intervention models are able to be measured, challenges are present when researchers attempt to quantify them. Applying science to a social science field is a difficulty that helps to keep the research field of residential treatment undeveloped and unfocused (Butler and McPherson, 2006).

The involvement of parents in treatment is also a challenge of residential care. Involving parents closely in residential treatment is often problematic because the child is away from home, with the treatment staff assuming many of the functions usually reserved for parents (Walter & Petr, 2008). Separation from parents is also common for residential treatment because parents are sometimes viewed as at least partially responsible for their child's emotional and behavioral problems (Walter & Petr, 2008). Despite these difficulties, most providers of residential treatment agree that treatment success is largely dependent on meaningful and sustained involvements of parents in the treatment process. Treatment of the child without involvement of the parents and family is unlikely to produce meaningful and long-lasting remediation of problem behaviors and emotions (Walter & Petr, 2008; Nickerson et al., 2007).

Lack of stability is another potential challenge in residential treatment centers. More intensive residential programs have been found to have the greatest placement stability (Sunseri, 2005). However, utilizing the concept of treating clients in the least restrictive environment possible, clients must first fail at lower level placements before being placed in a more intensive program (Sunseri, 2005). Research results (Sunseri, 2005) have found children exit the residential system sooner, and at a lower cost, when initially assessed accurately and placed at the appropriate level of care from the beginning of treatment.

Another current challenge in residential treatment care is a lack of funding. Due to the expense of the intensive treatment, government officials are cutting funds for residential treatment and supporting less costly, community alternative treatment modalities (Butler & McPherson, 2006). Another challenge of residential treatment is that

what a child receives from the treatment experience is not always evident until years later (Butler & McPherson, 2006). The limit setting provided, or a mentor provided there are often identified 10 to 15 years later as factors that helped clients to succeed (Butler & McPherson, 2006). This presents a problem for evaluating effectiveness of children's treatment.

Frensch and Cameron, 2004 conducted a study in which they gathered information from previous reviews of residential treatment, and available reports on individual studies through searching PsychINFO, on-line data base. They used discussion to highlight key findings, comment on examples, and summarize patterns. Their review emphasized studies of highly visible models of residential treatment based on their prevalence in the literature. They also emphasized studies with an identifiable research design that included a detailed treatment program, which described participants and utilized concrete methods to measure and assess outcomes.

First, an overview of characteristics common to children and youth in residential mental health placements was presented. Common characteristics of their families were also presented. The researchers then provided information on the studies of the effectiveness of group home residential treatment and studies of the effectiveness of residential treatment provided in residential treatment centers. Next, they identified trends found in the treatment, and trends found in post treatment adaptation. Last, the researchers noted additional factors linked to trends for short-term and long-term outcomes.

A limitation of the Frensch and Cameron study is that it was simply a review of existing literature. Limitations of the current methods used for studying residential

treatment were noted by Frensch and Cameron, (2004) in this study. The researchers noted there continue to be serious methodological flaws in research conducted in this area, outcome measures need to be reconsidered, treatment components need to be clearly defined and operationalized, and it needs to be clarified when residential treatment is warranted. They state that current research in the area of residential treatment suffers from poor credibility and limited application (Frensch & Cameron, 2004).

This research will replicate the above study, in that the existing literature will be reviewed for characteristics of children needing residential mental health treatment. The existing literature will also be reviewed for the effectiveness of residential mental health treatment. However, this research study will extend the review of existing literature by Frensch and Cameron, 2004, by also examining the parent-child relationship and its associations with the child's residential mental health treatment.

Frensch and Cameron, 2004 conclude: successful patterns of adjustment are associated with the post treatment environment to which a child is discharged. Children's functioning improves post-treatment when they are discharged into positive, stable, and supportive environments. Post treatment environments of successful children can be characterized by increased family support, residential stability, and the use of after care services. Children are commonly successful in post treatment environments that include a reduction in stress and an increase in family support (Lewis, 1982). The use of after care services by children and their families is also associated with sustained positive outcomes following treatment (Wells, 1991). This research will extend French and Cameron's study to further examine one aspect of the environment to which children are

discharged, the parent-child relationship and its associations with residential mental health treatment.

Frensch and Cameron, 2004 found the problems that led to the child's placement in residential treatment are commonly still present in the family upon return of the child to the home. "Families with multiple chronic problems may not be realistic support systems to which to return these children and expect them to maintain progress made in the treatment environment." This research will expand on Frensch and Cameron's 2004 literature review and the studies described within it by examining the parental perceptions of changes in the parent-child relationship before the child participates in residential treatment and after the child participates in residential treatment.

### **Summary**

In summary, the literature demonstrates a need for residential treatment for children. The research shows that residential treatment can be an effective form of mental health treatment for children. More work was required to fully understand the nature of the parent-child relationship when a child is placed in residential treatment. The literature is lacking research that examines specifics about the parent-child relationship when a child enters residential treatment. This research study examined specific components of the relationship that have not been found to have been examined in the literature, including: (a) parental support, (b) satisfaction with parenting, (c) parental communication, (d) parental involvement, (e) limit setting, and (f) discord in the relationship. This study also addressed another gap, as current literature is also lacking research that involves qualitative work that examines the lived experience of having a child in residential mental health treatment.

The literature available describes the importance of the parent-child relationship, and its impact on a child's mental health. However, research and literature on child and adolescent mental health issues in general, and residential mental health treatment effects on familial relationships, in particular, has been sparse. Patterson (1982, as cited in Harach and Kuczynski, 2005) argued that children's behaviors, notably non-compliance and aggression, have associations with the parent-child relationship in negative ways. Literature also has shown that a positive parent-child relationship is associated positively with parental well-being, and that a negative parent-child relationship is associated with adolescent's suicide risks. Through examining the parental perspectives of specific aspects of the parent-child relationship, this study helped to fill in the gaps in the literature.

Research has also shown that family involvement and support are key to the success of the treatment. More work was required to understand the association between children's residential treatment and the parent-child relationship due to the multiple gaps in the literature. There is little research available that examines the parent-child relationship for children receiving mental health treatment in a residential setting. Further research was needed to provide directions for residential mental health treatment, professionals and the parents of children placed in these programs. Research on residential treatment is lacking qualitative or exploratory studies. A research study that has a qualitative component added to the understanding of residential treatment and the parent-child relationship as it is associated to it. This research study examined Parental Support and Parental Involvement to help fill in the gaps in the research. Also, examining the parent-child relationship through examining the experience of having a child in



residential treatment from the parental perspective helped to fill these holes in the research. In summary, by examining six variables of the parent-child relationship, (Parental Attitudes, Parental Support, Satisfaction with Parenting, Parental Involvement, Communication, and Limit Setting) and its associations to residential mental health treatment for children, this research had the potential to inform and assist when professionals are developing protocol for residential treatment programs.

## **CHAPTER THREE**

### **METHODOLOGY**

This chapter will discuss the methodology of the research study. Healthy child development, a key determinant of health and resiliency in adulthood, may be affected by the quality of the parent child relationship (Letourneau et al., 2001). The quality of family functioning is important for physical health and psychological well being (Johnson, Kent & Leather, 2004). In the United States, four million children and youth suffer from a major mental illness that significantly impairs their functioning at home, school, and with peers (Butler & McPherson, 2006). Of those children, between 75% and 80% do not receive the mental health services that they need (Butler & McPherson, 2006).

When children do get the services that they need, mental health treatment for families often focuses on developing the parent-child relationship, with a main goal of therapy being to develop the parent-child bond in order to develop a more functional parenting style. Interventions designed to strengthen that parent-child relationship can be effective at alleviating behavioral disorders (Johnson et al., 2005). Research is needed to further examine these problems. The researcher will now discuss the methodology of the study designed to address some of those issues.

This research study combined both quantitative and qualitative research study components. Thus, this chapter is divided into two parts. The first part will describe the details of the quantitative research design. The second part describes the details of the qualitative research design. This mixed methodology was concurrent explanatory—the majority of the research was quantitative, with a qualitative piece added to supplement the research and answer an additional research question. A quantitative methodology

was also useful to add to the qualitative piece of this study to allow the researcher to gain a more in depth look at the topic and to gather a greater understanding of the experience. In a concurrent explanatory design, quantitative data and qualitative are collected and analyzed at the same time, but priority is given to the quantitative data (Hanson, Creswell, Plano-Clark, Petska, & Creswell, 2005). The qualitative data is used primarily to augment the quantitative data. The data analysis is connected, as the data is integrated at the interpretation stage, as well as in the discussion (Hanson et al., 2005). The concurrent explanatory study is useful for explaining relationships or study findings (Hanson et al., 2005).

### **Research Questions and Hypotheses**

The primary research question that this study investigated is: Is there a significant change in the parent-child relationship for children ages 5-13 years old with emotional and behavioral disorders who have received residential treatment? The following specific research questions were examined during this study:

- 1) Is there a significant change in perceptions of the parent-child relationship, as measured by the Index of Parental Attitudes at post-residential treatment for parents of children ages 5 to 13 with emotional and behavioral disorders?

H<sub>1</sub>: There will be a significant difference in parental attitudes post-treatment as evidenced by a *t*-score exceeding the critical *t*-value for the respective sample size. There will be significantly lower scores post-treatment, which indicate more positive parental attitudes toward children.

- 2) Is there a significant change in perceptions of the parent-child relationship, as measured by the Parent-Child Relationship Inventory scales, at post-

residential treatment for parents of children ages 5 to 13 with behavioral and emotional disorders?

- Is there a significant change in the level of support a parent perceives to be present, as measured by the Parental Support scale of the PCRI completed by the parents of children ages 5-13 with behavioral and emotional disorders at post-residential treatment?

H<sub>2</sub>: There will be a significant difference in level of support post-treatment as evidenced by a *t*-score exceeding the critical *t*-value for the respective sample size. There will be significantly higher scores post-treatment, which indicate the parents feel more supported and engage in more supportive activities.

- Is there a significant change in the degree of satisfaction with parenting that a parent perceives is present in the parent-child relationship, as measured by the Satisfaction with Parenting scale of the PCRI completed by the parents of children ages 5-13 with behavioral and emotional disorders at post-residential treatment?

H<sub>3</sub>: There will be a significant difference in degree of satisfaction post-treatment as evidenced by a *t*-score exceeding the critical *t*-value for the respective sample size. There will be significantly higher scores post-treatment, which indicate the parents feel more satisfied with parenting their child.

- Is there a significant change in the amount of parental involvement that a parent perceives is present in their parent-child relationship, as measured

by the Parental Involvement scale of the PCRI completed by the parents of children ages 5-13 with behavioral and emotional disorders at post-residential treatment?

H<sub>4</sub> : There will be a significant difference in parental involvement post-treatment as evidenced by a *t*-score exceeding the critical *t*-value for the respective sample size. There will be significantly higher scores post-treatment, which indicate greater parental knowledge of the child and an increase in the time the parent is spending involved with the child.

- Is there a significant change in the communication in a parent child relationship, as measured by the Communication scale of the PCRI completed by the parents of children ages 5-13 with behavioral and emotional disorders at post-residential treatment?

H<sub>5</sub> : There will be a significant difference in communication post-treatment as evidenced by a *t*-score exceeding the critical *t*-value for the respective sample size. There will be significantly higher scores post-treatment, which indicate more positive communication from the parent to the child.

- Is there a significant change in the limit setting by a parent in a parent-child relationship, as measured by the Limit Setting scale of the PCRI completed by the parents of children ages 5-13 with behavioral and emotional disorders at post-residential treatment?

H<sub>6</sub> : There will be a significant difference in limit setting post-treatment as evidenced by a *t*-score exceeding the critical *t*-value for the respective

sample size. There will be significantly higher scores post-treatment, which indicate greater limit setting by the parent.

- 3) What is the essence of the experience for a parent to have a child in residential mental health treatment, and how do parents perceive it to be experienced within the parent-child relationship?

This research question corresponds to the qualitative portion of the research design.

### **Part I: Quantitative Research Design**

The first component of this research study was a quantitative analysis of data on the discourse in the parent-child relationship as well as information regarding specific aspects of the parent-child relationship (communication, discipline, involvement, support, and satisfaction) before and after a child's residential mental health treatment. A quantitative approach allowed the researcher to obtain descriptive statistics regarding the aspects of the parent-child relationship, post-residential mental health treatment for children ages 5-13. The study was a non-experimental design. Data was analyzed to determine to what extent there are changes in parental perceptions of specific aspects of the parent-child relationship (Parental Support, Satisfaction with Parenting, Involvement, Limit Setting, and Communication) assessed after completion of child's residential mental health treatment.

For the design of this study, archival data were analyzed that had been gathered from a residential facility in the southeastern United States. The residential facility is a small facility that serves children ages 5 to 13 that exhibit emotional and behavioral problems. Children are referred by school officials or mental health providers, and

usually stay about three months for treatment. The children have a high degree of involvement with their families while at the center, including weekly counseling, weekly interaction activities, daily phone calls, and overnight home visits each weekend. The center is highly structured and children are on a behavior modification system throughout their treatment. The parents attend parenting classes and a weekly parent support group while the child is in treatment.

Parents at this facility completed the Parent-Child Relationship Inventory (Gerard, 2005) and the Index of Parental Attitudes (Hudson, 1993) between August 2008 and January 2010. The purpose of the inventories was for clinicians at the facility to assess the parent-child relationship for problems before after residential treatment as part of the clinical treatment plans. Parents of children receiving residential treatment services at this facility completed the two self-report measures described below as part of the intake process before their child received residential mental health treatment and as part of the discharge process after the child received residential treatment. All identifying information was removed from the inventories and the program administrator assigned an anonymous identification code to participants before this researcher used the data.

### **Participants**

The sample that was used to examine changes in the parent-child relationship consisted of the parents of children ages 5-13 who participated in a 12-week residential mental health treatment program located in the Eastern United States. All children in this program were referred for treatment based on behavioral and emotional disorders as referred by school officials or mental health treatment providers. School administrators, school counselors, community therapists, or psychiatrists referred the children due to

behavioral and emotional problems in the school, home, and community settings. The children at this center mainly have diagnoses such as Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder, and Mood Disorders. More information will be provided on the specific participants of the study. The children remained at the center during the week and went home during the weekends. Parents visited the center for family therapy once a week, attended a parent support group once a week, attended a parent-child interaction activity once a week, and also attended special events on a regular basis.

To clarify, the data that was being analyzed were given to parents of mostly male children, as that is the population most often referred for services related to externalizing problems at this facility. Participants were parents that had 0-4 other children living in their home. The data were collected on parents and children from various ethnic backgrounds, the majority being Caucasian or African American. The sample consisted of mothers, fathers, step-mothers, step-fathers, grandmothers, grandfathers, guardians, and others residing with the child and acting in the parenting role. Participants were eligible for this study if they resided with the child and acted in a parental role. The sample size was seventy cases. Assuming a moderate effect size at  $P = .80$  for  $\alpha = .05$ , a sample of 67 is needed (Cohen, 1992). The relationship between parents and seventy children in residential treatment were examined. This allowed for the collection of data from 103 parents, since many children had two parents who completed the assessments.

Simply stated, all of the data was used from the time frame specified, as long as the parent completed both the pre and post assessments. No cases were eliminated unless



they did not complete the data. The demographics of the sampling frame were: male and female parents of mainly Caucasian and African American children between the ages of 5 and 13 years old. Most of the children receiving treatment had diagnoses of mood disorders, Oppositional Defiant Disorder, and/or Attention Deficit Hyperactivity Disorder. The majority of the children were male. The children receiving treatment at the facility usually had between 1 and 3 diagnoses. The majority of children at the treatment center had a prior treatment history of only receiving outpatient counseling. The children had few siblings. Most parents declined to state their income. A majority of the children reside with parents who are in stable romantic relationships. These demographics provided a variety of characteristics for the sample.

### **Instrumentation**

The instrumentation utilized in the study will now be described. Two questionnaires were used to measure the parent-child relationship. Janssens et al. (2005) noted that questionnaires have the advantage of easy applicability and scoring and are widely used today. In their study, they found questionnaire ratings tap the same type of information as observation ratings, even though different informants make the ratings. Questionnaires are cost effective, and less intrusive than interviews. Bias can be reduced with questionnaires because there are no verbal or visual clues available from a researcher to influence responses. A final advantage of utilizing questionnaires in research studies is their familiarity. Most participants had some experience with completing questionnaires in the past, and thus were familiar with how to use them.

Janssens, DeBruyn, Manders, and Scholte (2006) noted that questionnaires have the advantage of easy applicability and scoring. They examined the parent-child

relationship with behavioral ratings and with relationship questionnaire assessments.

They found that their behavior ratings did correlate with each other and with the questionnaire scores for problem behavior. They found that the quality of the parent-child relationship correlated with the child's problem behaviors.

### **Parent Child Relationship Inventory**

Parent-Child Relationship Questionnaires were utilized in this research study. Coffman, Guerin, and Gottfried (2006) examined the psychometric properties of the Parent-Child Relationship Inventory (PCRI; Gerard, 1994). Their results revealed acceptable internal consistency for most scales. Their results also showed moderate to high one-year stability for all scales. Both the mothers' and the fathers' scores correlated with their views of the family climate. Poor performance was observed for the Autonomy scale.

Additionally, the Parent-Child Relationship Inventory (Gerard, 2005) was used in this study. It was selected because it is designed to be used in research settings and is a self-report instrument that assesses the relationship according to seven scales for closer examination of strengths and weaknesses of the parent-child relationship. Gerard defines the parent-child relationship as including parent-child interactions, as well as the attitudes, dispositions, and behaviors of mothers and fathers. The parents of the children in treatment completed the survey. The seven scales are: Parental Support, Satisfaction with Parenting, Involvement, Communication, Limit Setting, Autonomy, and Role Orientation. The scale assesses parents' attitudes toward parenting and toward their children, and is designed for clinical and research settings. The parent responds to 78 items on a 4-point Likert scale. The ratings on the scale range from 1 (strongly agree) to 4

(strongly disagree). Most clients complete the form in about 15 minutes (Gerard, 2005). The range of scores in each scale is 0 to 100.

The norming sample of the PCRI consists of responses from 1,100 mothers and fathers in each major region of the United States. The sample consisted of parents with children ages 3 to 15. A benefit of the PCRI is the norming sample is based on the responses of both mothers and fathers. Most of the data comes from parents with a single child. The PCRI standardization sample is somewhat less diverse than the U.S. population as a whole, and somewhat more educated than the U.S. population as a whole (Gerard, 1994).

Further, seven content scales make up the PCRI. The Parental Support scale consists of 9 items that assess the level of emotional and social support a parent receives. Examples of items from this scale are: "When it comes to raising my children, I feel alone most of the time," and "I sometimes feel overburdened by my responsibilities as a parent." The range of scores for this scale is 0 to 100. The alpha coefficient for this scale taken from the norming sample is .70.

The PCRI also contains a Satisfaction with Parenting scale. The Satisfaction with Parenting scale consists of 10 items measuring the amount of pleasure and fulfillment an individual derives from being a parent. Examples of items from this scale are: "I get as much satisfaction from having children as other parents do," and, "I regret having children." The range of scores for this scale is 0 to 100. The alpha coefficient for this scale taken from the norming sample is .85.

Additionally, there is an Involvement scale in the PCRI. The Involvement scale contains 14 items measuring the level of a parent's interaction with and knowledge of his

or her child. Examples of items from this scale are: “I spend a great deal of time with my child,” and, “I feel I don’t really know my child.” The range of scores for this scale is 0 to 100. The alpha coefficient for this scale taken from the norming sample is .76.

There is also a Communication scale on the PCRI. The Communication scale consists of 9 items that assess a parent’s perception of how effectively he or she communicates with a child. Examples of items from this scale are: “My child generally tells me when something is bothering him or her,” and, “If I have to tell no to my child, I try to explain why.” The range of scores for this scale is 0 to 100. The alpha coefficient for this scale taken from the norming sample is .82.

Additionally, the PCRI contains a Limit Setting Scale. The Limit Setting scale contains 12 items that focus on a parent’s experience disciplining a child. Examples of items from this scale are: “I have trouble disciplining my child,” and, “I wish I could set firmer limits with my child.” The range of scores for this scale is 0 to 100. The alpha coefficient for this scale taken from the norming sample is .88.

The PCRI also has an Autonomy scale. The Autonomy scale assesses the ability of a parent to promote a child’s independence. Examples of items from this scale are: “I can’t stand the thought of my child growing up,” and, “I have a hard time letting go of my child.” The range of scores for this scale is 0 to 100. The alpha coefficient for this scale taken from the norming sample is .80.

Finally, the PCRI contains a Role Orientation Scale. The Role Orientation scale is comprised of 9 items and examines parent’s attitudes about gender roles in parenting. Examples of items from this scale are: “A woman can have a satisfying career and be a good mother, too,” and, “A father’s major responsibility is to provide financially for his

children.” The range of scores for this scale is 0 to 100. The alpha coefficient for this scale taken from the norming sample is .75.

The PCRI also includes two validity indicators: the Social Desirability Scale, which indicates whether the client was operating with a defensive or “fake good” response set, and an Inconsistency Indicator, which indicates if the parent may have been responding randomly or inattentively (Gerard, 2005).

In order to score the PCRI, the number circled by the parent for each item was transferred to the corresponding box. Values then were added up for each column. Those sums were added to get the final raw scores for those scales. Raw scores were transferred from the scoring page to the PCRI Profile Form and the raw scores were plotted. Scores are expressed as normalized *t*-scores with a standard deviation of 10 and a mean of 50. Lower scores indicate poor parenting skills and higher scores indicate good parenting skills. A score less than 40 on any PCRI scale suggests problems in that area. A score of less than 30 on any PCRI scale suggests serious problems in that area (Gerard, 2005). There is no final total score used; only subscale scores are used.

It is significant that recent research has supported the validity of the PCRI (Coffman, Guerin, & Gottfried, 2006). Coffman et al. noted ranges of internal consistency and test-retest reliability for the scales this study utilized as .68-.88 and .59-.82, respectively. Thus, the psychometric properties of the PCRI were examined and results revealed acceptable internal consistency for *most* scales and moderate to high 1 year stability for all scales (Coffman et al., 2006). The Autonomy scale had the lowest test-retest reliability (.59). Samples sizes reported are as follows:  $n = 80$  for mothers,  $n = 67$  for fathers,  $n = 66$  for mother’s stability,  $n = 52$  for father’s stability. Using the

criterion that coefficient alpha values should be at least .70 to provide a fair level of internal consistency, all scales except Communication (alpha = .68) reached an acceptable level (Ponterotto & Ruckdeschel, 2007). Communication was utilized in this study, due to its importance in the parent-child relationship noted in the literature previously, and due to the closeness of .68 to the .70 goal.

Further, the PCRI has good overall internal consistency with a median alpha value of .82 (Gerard, 2005). The standardization sample ( $n=1093$ ) was used to estimate the internal consistency of the PCRI scales. For a sample size over 300, with fewer than 12 items per subscale, an alpha value of .82 is considered moderate (Ponterotto & Ruckdeschel, 2007). The PCRI also has good test-retest reliability with a mean scale autocorrelation of .81 (Gerard, 2005). The construct validity based on internal consistency and the correlation of each individual item with its scale, is also good (Gerard, 2005). Content validity was established through scale construction intended to ensure that items as a group characterize important parenting values and attitudes, generated based on a review of the parenting literature (Gerard, 2005).

Additionally, predictive validity is evidenced by a study correlating scores on the PCRI with scores on the Personality Inventory for Children, which showed significant correlations between all scales except for the Communication Scalee (Gerard, 2005). Gerard noted the PIC's scales are associated with parent-child relationship factors. Good construct validity is shown for the PCRI through high levels of internal consistency and because scores for most items in the PCRI are more strongly correlated with their own scale totals than they are with the totals of other scales (Gerard, 2005).

However, the Autonomy scale was not used in this study. Gerard (2005) reported the alpha level for this scale to be .80, based on a sample size of  $n = 1,093$ , indicating an acceptable reliability level for research measures (Ponterotto & Ruckdeschel, 2007). However, when used by other researchers, it has revealed unacceptable levels of internal consistency. Coffman et al. (2006) examined the psychometric properties of the PCRI, and found poor performance for the Autonomy scale. Problems were evident and the researchers questioned the value of this scale. Internal consistency coefficients failed to meet an acceptable level for both mothers and fathers 15 and 16 year olds of 130 15 year old participants from the Fullerton Longitudinal Study, a contemporary study of children and their families. Alpha levels for mothers were .47 and alpha levels for fathers were .54 (Coffman et al., 2006). In a study with a sample of mothers ( $n = 80$ ) and fathers ( $n = 67$ ), on scales with less than 12 items per subscale, alpha levels of .47 and .54 respectively, are both deemed unsatisfactory levels of internal consistency (Ponterotto & Ruckdeschel, 2007). An alpha level of .70 would be needed to make the rating fair.

Other researchers also reported similar findings (Reitman et al. 2001, 2002; Suchman & Luthar, 2002) with younger children. Reitman et al. (2001) utilized the PCRI in a study of 3 to 5 year old children. A sample of 216 mothers completed the instrument. Coefficient alpha was found to be .55 for the autonomy scale in this study. Using the criterion of .70 for an acceptable internal consistency level, this scale was again found to be at an unacceptable level of internal consistency (Ponterotto & Ruckdeschel, 2007).

When examining the convergent validity of this scale, researchers looked at the cross-informant convergence with the Self Description Questionnaire-II and Family Environment Scale. Mother's reports on PCRI scales excluding the Autonomy scale

correlated positively with adolescents' perceptions of their relationships with parents SDQ-II and family cohesion; correlates with conflict in the family were negative (Coffman et al., 2006).

Likewise, Henze and Grisso (1996) note that assessing autonomy is problematic due to the fact that adjustments parents make in nurturing independence are based on their perceptions of what their children need, and this is not reflected in measures of the construct. Marchant and Paulson (1998) raised the concern that cultural norms may vary considerably with respect to the construct of autonomy in Western versus non-Western societies.

In conjunction with this, the Role Orientation scale was also not used in this study. The scoring on this scale is inconsistent with the scoring on the other scales, in which consistent with the idea that parenting skills define a positive dimension, higher scores on the other scales indicate good parenting skills and lower scores indicate poor parenting skills. Rather than representing a dimension on which there are clear negative and positive poles, this scale represents two different approaches to shared parental responsibility (Gerard, 2005). Rather than assessing an aspect of the parent-child relationship, this scale examines parent's attitudes about gender roles in parenting. Gerard advises only using this scale with caution, because both role orientations can be functional and both reflect deeply held values. The attitudes measured by the Role Orientation scale are presently the subject of controversy in our society (Gerard, 2005). Lower scores on this scale indicate traditional attitudes toward gender roles. Gerard advises using caution with this scale not to confuse the positive and negative role orientation scale values with positive and negative social values.



Gerard (2005) reported the alpha level for this scale to be .75, based on a sample size of  $n = 1,093$ . In a study of 3 to 5 year old children and their mothers ( $n = 216$ ) utilizing the PCRI, the alpha coefficient for the Role Orientation scale was found to be .55. This is again an unacceptable level of internal consistency (Ponterotto & Ruckdeschel, 2007).

### **Index of Parental Attitudes**

The parent-child relationship was also measured in this study by the Index of Parental Attitudes (Hudson, 1993), a paper-pencil, self-report assessment tool that measures the degree, severity, or magnitude of personal and social functioning problems in a parent-child relationship as perceived by the parent (Hudson, 1997). It is a family relationship measure that measures the construct of discord with the child (Hudson, 1997). Practitioners designed the IPA for use and researchers in repeated administrations with the same clients to assess initial problem status and to monitor client progress over time and to monitor the course of treatment (Hudson, 1997). The scale is especially useful in human service organizations to evaluate change (Hudson, 1997).

The parents completed the IPA with respect to the parent's relationship with a specific child. In completing the IPA, the parents responded to 25 items on a 7-point Likert scale. The ratings on the scale range from 1 (none of the time) to 7 (all of the time). Most clients complete the form in 5 to 10 minutes (Hudson, 1997). Examples of items from the measure include: "I feel ashamed of my child," "I do not understand my child," and "I get along well with my child." The range of scores is 0 to 100 for this instrument.

To score the IPA, the items corresponding to the numbers listed below the copyright notation of the scale were reverse scored using the computation  $X = K - Y + 1$  where X is the reverse scored value and Y is the original score provided by the respondent. K is the largest item response permitted. Next, all items were summed. The number of correctly completed items was subtracted from the sum. That number was then multiplied by 100. The result was then divided by (the number of completed items) multiplied by (K - 1). The score should then range between 0 and 100 (Hudson, 1997).

Scores range from 0 to 100, in which higher scores indicate greater problems with the parent-child relationship. On the IPA, the scores are true ratio values. A score of 0 indicates the client has no problems in the parent child relationship and a score of 100 represents the highest possible distress level that the scale is capable of measuring. A low score indicates the relative absence of problems in the parent-child relationship, and higher scores indicate the presence of a more severe problem in the parent-child relationship. A clinical cutting score is 30, meaning scores above 30 are indicative of problematic parent-child relationships and scores below 30 are indicative of a non-problematic parent-child relationship. The second clinical cutting score is 70, meaning that clients who achieve scores this large or larger are nearly always experiencing severe distress. Scores above 70 indicate a clinician should be alert for signs of violence or child abuse.

In addition, the IPA has been found to have good content, concurrent, factorial, discriminate, and constructive validity. According to the WALYMAR Assessment Scales manual, the reliability alpha for the IPA is 0.97, the standard error of measurement is 3.64, and the known groups validity is 0.88 (Hudson, 1997). The IPA is part of the

WALMYR Assessment Scales, and is an accurate and reliable means to evaluate clients before, during, and after treatment (Hudson, 1997). The IPA is reliable and valid (Hudson, 1997). The IPA is useful for repeated administration with the same clients because it is short; easy to administer; easy to score; easy to understand and interpret; and it does not suffer response decay when used repeatedly (Hudson).

Two indexes were chosen to be used for this study because both are useful in unique ways. The IPA was useful for this study because it gave a score of the severity of distress in the parent-child relationship, and was designed for monitoring intensity of the problem. The IPA was also useful because it gave a clinical cutting score, a clear indicator of the problem. It was also chosen because it has a cutting score that indicates the relationship has very serious problems and when the likelihood of violence is a distinct possibility. A score of 70 or larger indicated a clinician must investigate and rule out potential child abuse. The IPA addressed specific aspects of the parent-child relationship: the amount of discord in the relationship, and the magnitude of the personal/social functioning problems in the relationship. The PCRI was useful for this study because it uses scales to break down the specific aspects of the parent-child relationship into strength or weakness areas. It identified specific aspects that may cause problems in the parent-child relationship. Rather than providing a single score that represents an overall ability, this instrument utilizes specific scales that reflect major features of the parent-child relationship. The PCRI scales addressed specific aspects of the parent child relationship: the amount of pleasure a parent gets from parenting, the level of interaction a parent has with the child, how effectively the parent communicates with the child, and the parent's experience disciplining the child.

## **Demographics Sheet**

In addition to the above assessments, a demographics sheet was utilized in this study. Residential client records were examined in order to gather demographic data on children and parents. All identifying information will be removed and the administrator coded client records before giving them to the researcher for use in this study. Specifically, intake forms completed by parents prior to residential treatment admission and admission screening forms completed by the treatment clinician were examined for demographic information. Residential client records will be examined for information including the child's age; gender; ethnicity; parental relationship status; household income; number of siblings in the home; child's diagnoses at admission; number of diagnoses at admission; and prior treatment history, including number of previous residential placements, number of previous psychiatric hospitalizations, and number of previous attempts at outpatient counseling.

## **Data Analysis**

Data were analyzed using several paired sample *t*-tests. Specifically, the researcher examined change scores for the six variables (the IPA, and the five subscales of the PCRI: parental support, satisfaction with parenting, parental involvement, communication, and limit setting). A *t*-test was used to assess hypothesized mean differences for these subscales (Green & Salkind, 2005). For a repeated-measures design paired sample *t*-test, participants are assessed on two occasions. Each participant has two scores, one representing the first score on the measure, and one representing the second score on the measure. The primary question of interest is whether the mean difference between the scores on the two occasions is significantly different from zero (Green &

Salkind, 2005). This type of *t*-test is useful when an intervention is used, to assess the scores pre and post intervention to determine if there is a significant difference. It is used to compare means. Assumptions for conducting *t*-tests were tested. The first assumption that must be met by a paired sample *t*-tests is that the different scores are normally distributed in the population (Green & Salkind, 2005). If the population is non-normally distributed, the power of the test may be reduced. Also, in non-normally distributed populations, a larger sample size may be required to obtain valid *p* values. A second assumption for paired sample *t*-tests is cases represent a random sample from the population and the difference scores are independent of each other (Green & Salkind, 2005). If that assumption of independence was violated, inaccurate *p* values would occur. Demographic data was also gathered utilizing a demographics sheet and case records examination and presented as descriptive statistics.

To clarify, a paired sample *t*-test was used rather than an ANOVA or another statistical test because the researcher was comparing the means pre and post intervention to determine if there was a significant difference, and a *t*-test is the most appropriate statistical test for this. A paired sample *t*-test was used because the same group of participants was used for both sets of testing, and the same assessments were given both before and after the intervention. The *t*-test was most appropriate for this repeated measures design.

Specifically, SPSS version 17 (SPSS, 2008) was used to complete all statistical procedures. The researcher compared the scores of the 5 PCRI scales and the IPA completed by the parent pre-treatment to the scores of the 5 PCRI scales and the IPA that were completed by the parent post-treatment in order to determine the relationship the

child's residential mental health treatment had with the parental perceptions of the parent-child relationship.

### **Internal and External Validity Threats**

Internal and external validity threats must be considered in all good research studies. Internal validity is the degree to which a study establishes the cause-and-effect relationship between the treatment and the observed outcome. It refers to the degree the treatment or intervention effects change in the dependent variable. External validity asks the question of generalizability: to what populations, settings, treatment variables and measurement variables can this effect be generalized? (Campbell & Stanley, 1966). Internal validity threats were controlled for to the extent that it was possible in a study using already existing data. One validity threat was attrition. Not every family was able to complete the study. Not all children that started the residential program completed it. Some parents refused to take the tests upon discharge.

Maturation was another internal validity threat. Participants in this study completed the instruments first during their child's admission to treatment, and again during their child's discharge from treatment three months later. The participants may have changed during these three months between measurements. The criteria for using the scores in the study will be: all data sets that were completed by a parent before and after residential treatment; and all data that had PCRI tests with scores on the two validity indicators that indicated the test was valid (the Social Desirability Scale and the Inconsistency Indicator).

An additional validity threat was that the researcher was employed as a clinician at the residential facility in which the data was collected. This could have biased the

study. However, since the study utilized data that had already been collected, this bias was minimized.

Treatment fidelity was also a validity threat in this study. The researcher could not be certain how faithfully the treatment program intervention was carried out at the residential treatment center. The child participants could have experienced different aspects of treatment depending on how accurately the individual clinicians carried out the treatment interventions.

Finally, repeated testing was an internal validity threat. The parents took the same test when the children entered treatment that they took when the children discharged from treatment. They may have become familiar with the questions.

External validity threats were a risk in this study as the researcher had little control over the internal factors in the study. By using existing data there was no chance of controlling inside the study.

### **Summary**

In summary, the purpose of this study was to determine the effects of residential treatment of children on parent-child relationships. It was hypothesized that residential treatment would be correlated with increased satisfaction with parenting, increased parental support, increased communication, increased involvement, increased limit setting, and less discord in the parent-child relationship. The data were collected from an Eastern United States residential program, and was archival. The data were analyzed using *t*-tests. The research questions, hypotheses, participants, procedures, instrumentation, data analysis, and validity threats have all been discussed in detail in this chapter. It is hoped that this study will build upon the existing literature and provide

directions for future research in the areas of children's mental health, parent-child relationships, and residential treatment.

### **Part Two: Qualitative Design Description**

The second part of the mixed methods design was qualitative in nature.

Qualitative research methodology was utilized specifically through the phenomenological approach. How a parent experiences his or her child's residential treatment and the parent-child relationship was explored in depth. This chapter describes qualitative research, the rationale for utilizing it in this study, paradigm for the research, theory behind the research, purpose of the study, the researchable problem, research question, the research design, role of the researcher, assumptions and biases, the research team, the research plan, participants, ethical considerations, subjectivity and objectivity, data collection and analysis, limitations, and strategies to increase the credibility of the study.

The qualitative methods used here are part of the postmodern/constructivist tradition and stress the socially constructed nature of reality. The central activity of conducting qualitative research is fieldwork. The qualitative research design is naturalistic as the research is done in the setting of the real world, without the researcher attempting to manipulate the variables being studied (Patton, 2002). Inductive approaches are utilized to gain understanding into the participant's views of their lived experiences. Qualitative researchers emphasize description over explanation. The data which is produced describes the participants' views of their experiences. This study aimed to describe the phenomenon of a parent having a child in residential mental health treatment, and how that experience is lived out in the parent-child relationship. In qualitative research, researchers attempt to gain an understanding of how the participants



act, think, and feel, while examining issues in depth and in detail (Patton, 2002). In this study, the researcher examined the lived experience of parents that had a child receiving residential mental health treatment, and explored that parent-child relationship. The researcher functions as the instrument in qualitative research. Researcher assumptions and biases must be named and safeguards must be put in place so that they do not interfere with the study. The qualitative research study produces a wealth of detailed data from a small number of cases (Patton, 2002).

### **Rationale for Using Qualitative Methodology**

This research study followed a phenomenological tradition because it investigated the lived experience of the participants and because its goal was to explore in depth the lived experience of a parent that has a child receiving residential mental health treatment; specifically examining the parent- child relationship in this circumstance. The rationale for using qualitative methodology was to add a more in depth focus to the quantitative data already collected for this research study. This researcher sought to gain more knowledge about the experience of the parent when a child is in residential mental health treatment and the parent-child relationship within that circumstance. The researcher studied the meaning of this experience for these families. Qualitative methods typically produce a wealth of detailed information (Patton, 2002),.

Methodology is a way of studying and thinking about social reality (Straus & Corbin, 1998). Phenomenology explores how individuals make sense out of their experiences and how they then transform those experiences into their consciousness. The methodology of this research included characteristics of the qualitative research philosophy, including: examining the lived experience of parents who have a child

receiving residential mental health treatment, fieldwork in a naturalistic setting without attempting to manipulate the phenomenon, studying a small number of cases in depth, and having an interview protocol set up to have parents describe how they think and feel about their children being in residential mental health treatment and the parent-child relationship within that.

### **Research Paradigm and Tradition**

The research paradigm for this study was social constructivist, as it is believed that multiple realities of this phenomenon exist and are constructed through social interactions. From the social constructivist viewpoint, there is no universal truth (Patton, 2002). In terms of this research study, the experiences of one parent with a child in residential mental health treatment may not mirror the experience of another parent with a child in residential mental health treatment. This research study encouraged the exploration of different views of the phenomenon. The researcher was open to different realities. Social constructivism refers to individuals constructing these realities in a social context. The context about perceived relationships is the family, and potentially the treatment facility.

Since the purpose of the investigation was to examine how parents of children in residential treatment conceptualize that experience and the parent-child relationship within that experience, phenomenological procedures appeared appropriate for this research. The phenomenological approach examines how people make meanings from experiences. It focuses on how participants construct their worldviews from their lived experiences. The experiences of the participants were compared and analyzed in order to identify the essences of a phenomenon. “A phenomenological study focuses on

descriptions of what people experience and how it is that they experience what they experience” (Patton, 2002, p. 107). This study was phenomenological, as it addressed the phenomenon associated with the unique meaning making and subjective experiences of participants. Specifically, the phenomenon under study was the phenomenon of a parent having a child receiving residential mental health treatment services and the parent-child relationship within that situation. Core characteristics of phenomenological research are that it is: descriptive, it investigates the intentional relationship between persons and situations, and it provides knowledge of psychological essences (Wertz, 2005).

This portion of the research study examined in depth what those parents experienced and how they experienced having a child in residential mental health treatment, as well as the parent-child relationship within that experience. The different participants’ experiences were compared and analyzed. The research study also examined in depth how those parents conceptualized the parent-child relationship and how they experienced it.

### **Role of the Researcher**

In qualitative research, the researcher is the main instrument in data collection and analysis and thus plays a large role in the research study. The credibility of the study depends on the competence of the researcher- to a great extent (Patton, 2002). In this study, the primary researcher was a co-facilitator of the focus group interview and was one of the data analysts. The primary researcher asked questions and made observations in the focus group, as well as developed code books to develop common themes found among participants. The primary researcher was the primary investigator for this project, and communicated directly with the dissertation committee and chair for support.

In qualitative research, the researcher also functions as the instrument. Researcher assumptions and biases must not interfere with the researcher's ability to collect and analyze data appropriately. Objectivity and subjectivity need to be balanced. In this study, the primary researcher and author was a middle class, Caucasian female. The primary researcher did work at the residential treatment center for two years, so that may have biased the opinion of the researcher. With regards to personal biases, the primary researcher believed the residential mental health treatment of children can have positive effects on the family relationship. Consequently, the primary researcher consulted with other research team members, the dissertation chair, and the dissertation committee so that the research data could be accurately reported and assessed. To minimize researcher bias, the research team varied in age, ethnicity, gender, and counseling background. Prior to beginning the study, the research team had a discussion regarding their biases and assumptions. Bracketing "is the first step in phenomenological reduction" (Creswell, 2007, p.235). It is avoiding judgments, acknowledging biases, and blocking them both from entering the research process. For this study it was the process of setting aside the researchers' biases, personal views, and pre-judgments to allow the true experiences of participants to emerge throughout the analysis and synthesis of data.

### **Research Team**

The research team members and their duties will be described below.

**Primary Researcher:** The primary author and researcher was a Caucasian, single female, aged 31. She was a doctoral candidate of Counseling at Old Dominion University in Norfolk, Virginia. She holds a Bachelor's Degree from Virginia Tech in Psychology and a Master's Degree from Chaminade University in Counseling

Psychology. She was a Licensed Professional Counselor in the state of Virginia. She had nine years of counseling experience. She was a full time student at the time of the research. The role of the primary researcher was to oversee all aspects of the research study, including designing the methodology, research questions, and interview protocol, selecting and recruiting participants, training the research team, collecting data, functioning as part of the research team, and reporting the findings. She also was a co-facilitator of the focus group interview and developed codes as part of the data analysis process.

Research Team Member One – Research team member one was an African American, partnered, heterosexual male, aged 43. He was a social worker in Norfolk, Virginia. He owned his own counseling agency that focused on serving at risk, inner city youth. He had 25 years counseling experience at psychiatric hospitals, substance abuse centers, and in-home counseling agencies. This research team member's role was to co-facilitate the focus group interview and to develop codes and analyze data with the primary researcher.

Research Team Member Two- Observer. Research team member two was a Caucasian, partnered, heterosexual female in her 50's. She had 15 years counseling experience and was currently seeking licensure as an LCSW in Virginia Beach, Virginia. She had experience working with the court system and with residential facilities throughout the state. This member's role was to observe participants reactions and notice anything that the interviewers might miss while busy asking the interview questions during the focus group interview. This member documented the process of the focus group interview, and noted a description of the setting and participants.

All research team members were trained in qualitative focus groups and used a manual by vice president of Institutional Research and Assessment, Worth Pickering. The primary researcher and research team member one reviewed transcribed transcripts of the focus group interviews, and triangulated the process of selecting codes, themes, and patterns of the data. The observer was guided by the primary researcher on how to conduct observations utilizing a worksheet used by the dissertation chair, Dr. Hays in her research.

### **Strategies to Maintain Objectivity**

All researchers need to remain objective because becoming overly involved can cloud the researcher's judgment (Patton, 2002). Since pure objectivity is impossible, the primary researcher aimed to maintain a balance between subjectivity and objectivity (Patton, 2002). The primary researcher was open to learning about the essence of the experience from the parental point of view. Two researchers were present to ask questions in the focus group (a third researcher provided observations), and two researchers analyzed the data. Two interviewers were utilized for this focus group. The researchers identified their own biases and assumptions so that they would not interfere with the emergence of the participants' perceptions. The primary researcher sought out alternative explanations and hypotheses for the findings. The primary researcher was balanced in reporting confirmatory and disconfirming evidence with regard to conclusions offered. In an attempt to maintain objectivity, while balancing it with subjectivity, Patton advises using a middle ground stance of empathic neutrality. The researchers strove to achieve this throughout the study.

## **Researcher Subjectivity**

Also throughout the study, the credibility of the research study would be undermined through having pure subjectivity of the researcher (Patton, 2002). Therefore, the researchers aimed for a balance between subjectivity and objectivity. Researchers need subjectivity in their research because being too distant would reduce the researcher's understanding of the phenomenon they are studying, and reduce their understanding of the participants (Patton, 2002). Researchers need to understand and own their subjectivity. Researchers need to use their own inner experiences to better understand the subject being studied. Researchers need to be able to be self reflective and to understand their own personal experiences and how those affect their research.

## **Strategies to Maintain Subjectivity**

For example, since there are benefits to subjectivity in research, researchers can explore and manage their biases through reflexivity. Researchers need to identify their subjectivity. The researcher in this study utilized a peer debriefer. The researcher chose a peer debriefer for this study who had previous experience with qualitative research studies. The peer debriefer and auditor was a single, 50 year old, Caucasian female, who has a doctoral degree in counseling from an Eastern U.S. University and has experience researching and working as a counselor in various mental health settings. Utilizing a peer debriefer assisted the primary researcher to reflect upon her experiences and to understand them. The primary researcher utilized a reflective journal to further increase subjectivity. Patton (2002) recommends "understanding and depicting the world authentically in all its complexity while being self-analytical, politically aware, and

reflexive in consciousness” (p. 41). The research team aimed to do this throughout the study.

### **Research Plan**

In qualitative research, the researcher must take into account the study’s purpose and the audience, so the method becomes dependent on context (Patton, 2002). When selecting a method in qualitative inquiry, the researcher also must consider the resources available, criteria used to judge the quality of the findings, what questions will guide the study, and what data will answer those questions. No rigid rules or formulas exist for selecting appropriate methods for certain research problems (Patton, 2002). Considering the above listed criteria, the method chosen as most appropriate for this context by the primary researcher was one focus group interview of participants selected through purposeful criterion based sampling.

The researcher chose a focus group interview as most appropriate for this qualitative research for several reasons. As an objective of qualitative research is to be unobtrusive, a focus group interview fit these criteria because the residential center already had a group of parents going to the facility on a regular basis that could be selected from for interviewing. Options such as individual interviews were considered, but ultimately rejected due to the time constraints already placed on these parents to come to the center several days a week and to participate in so many different things. Also, in focus groups, individuals have a chance to hear others speak about a topic and add on to it, which is a benefit that could not be utilized if the researcher used an individual interview. The group members already knew each other from the support group and were comfortable talking among each other. It was assumed they may provide more in depth



information in a similar group interview format than they would in a one on one context with an interviewer that they did not know and did not already have an established familiarity.

### **Participants and Sampling Procedures**

In qualitative research, the research sample is used to gain insight about the phenomenon of interest, rather than generalizing to the population from the research sample. Cases are selected purposefully and strategically that will be information rich (Patton, 2002). A purposeful sampling procedure was used for this study in order to get information rich participants. To gather information rich data, researchers must study individuals who have lived the experience, or directly experienced the phenomenon of interest. In order to do this, criterion based sampling was also utilized for this study. Criterion sampling is studying cases that meet some predetermined criterion of importance (Patton, 2002). All cases are picked must meet that certain criterion. The criterion used for this research study was any parent or parent-figure who has a child currently receiving residential mental health treatment at the facility under investigation in this study. The same facility had been used for archival data collection for the first part of the study. The researcher went back to the same facility and obtained permission to hold a focus group interview from the administrator.

The residential facility was a mental health treatment facility for children ages 5-13 who had been referred from therapist, school officials, or parents for behavioral, social, school, or mental health problems. Their treatment lasted three months. During this time they went home on the weekends and saw their families several times a week for family counseling sessions, parent-child interaction activities, outside appointments,

and special events. The families came to the center often for parenting classes, support groups, and therapy. The children called home almost every day.

Participants were recruited from the mandatory parent support group that meets weekly at the facility. Participants were actually mothers, fathers, step-mothers, step-fathers, grandmothers, grandfathers, etc. of the children served at the facility, as long as they were serving in the parenting capacity. The only criteria for participation was to be a parent with a child in the residential treatment facility, however the primary researcher was aiming to have a variety of genders and ethnicities represented. The researcher also aimed to have a diversity of parents with respect to the amount of time their children had been in residential treatment.

The research team attended the support group one evening in June 2010. All parents at the support group that evening had the research study procedures explained to them by the primary researcher and they were asked if they were willing to participate in the study. Those that volunteered and provided their written informed consent were used as participants for this research study. In qualitative inquiry, there are no rules for sample size (Patton, 2002), however the number of parents available for the focus group that evening was 6, due to low attendance at the parent support group that evening. The focus group interview was held in a therapy room at the residential treatment center under study. Demographic sheets were completed by each parent in the focus group, providing information on themselves and their child in residential treatment.

## **Ethical Considerations**

### **Measures to Ensure Confidentiality and Safety**

Participants were explained the study in depth at the time of recruitment. They were also provided with a copy of their signed consent form. Participants signed a release of confidentiality and agreement to be digitally recorded and for this information to be used in a research study (see Appendix B). No identifying information was written down. Participants were identified as numbers or letters only. No identifying information was given in the research study about the participants. The audiotapes were destroyed after use and were kept in a locked cabinet behind a locked door at all times while kept for the study. Regarding protection of participants, participants were explained that declining to participate in the study would not result in any negative consequences or restriction of privileges normally enjoyed by their family or children in the residential treatment program.

Also, in a group setting, some participants may be less likely to disclose information, or they may be less honest. Also, sometimes in a group setting one person will try to dominate the conversation, or another may not speak at all. However, the interviewers from the research team had group facilitations skills and utilized these to manage these potential risks and to help members feel safe to disclose information. Also, at the beginning of the group the facilitators discussed that confidentiality cannot be guaranteed in a group setting. Research team members were prepared that research participants may have revealed information that is very emotional for them. They had a plan that if any clinical concerns arose, the research team members would discuss these concerns privately with the participant, and refer them for appropriate services, if needed.

The research team would then consult with the dissertation chair and follow up to ensure appropriate actions were taken.

The study was reviewed by the Old Dominion University Institutional Review Board (see Appendix A) before research officially began, in order to ensure proper treatment and safety of the participants. The researcher presented an application detailing the exact research plan, including plans for confidentiality and safety of the participants. The Old Dominion University Institutional Review Board reviewed this and approved it before any research was initiated.

### **Data Collection Procedures**

The main data collection procedure utilized for this qualitative part of the research study consisted of one focus group interview with participants chosen through purposeful criterion based sampling. This was conducted on one occasion during the weekly parent support group meeting at the residential treatment facility under study. During the focus group interview, the research team also made observations that were used as data. Finally, data were collected through document reviews of the demographics sheet.

### **Data Sources**

The data collection procedure utilized in this study was a focus group interview. The focus group interview is a frequently used source of qualitative data. A focus group is a type of interview in which the participants are able to listen to each other's responses and add additional comments to their own original responses when they hear what other participants have said (Patton, 2002). It is different than an individual interview because it is held in a social context in which the participants are able to consider their own views in the context of other persons' views. Focus groups are usually conducted for 1 to 2

hours on a specific topic, with people of similar backgrounds (Patton, 2002). The focus group interview in this study was held during the parent support group meeting at the children's residential facility. The purpose of any qualitative interview is to give the participants a voice and for the researcher to hear and understand what they think (Siedman, 2006). A focus group interview was used as the major source of qualitative data in this study in order to gain insight into the participants' experience of having a child receiving residential mental health treatment and the experience of the parent-child relationship. The interview lasted approximately 90 minutes. This was a face to face interview that was audio recorded and transcribed. The discussion in the focus group was designed to allow participants to describe that experience.

### **Focus Group Interview**

In qualitative interviewing, the interviewer asks open ended questions in the form of main questions, probes, and follow-up questions. Questions change depending on what the researcher learns or fails to learn (Siedman, 2006). In phenomenological interviewing, the major task for the researcher is to build upon the participants' responses to the questions and explore the responses further. The goal of the phenomenological interviewing is for the participants to reconstruct their experience with the phenomenon being studied (Seidman, 2006). An interview protocol was designed previous to the focus group interview. A total of 8 questions were asked of the participants (see Appendix E). The interview protocol was used as a guide for discussion in the group. The participants were asked a series of open ended questions about their relationship with their child and residential treatment in general. Examples of questions are, "What have you noticed about your relationship with your child since he or she has been in

residential treatment?” and, “How has, if at all, residential treatment been helpful to your family? (see Appendix E for the interview protocol). One question was asked to encourage alternate explanations or to let new themes emerge. Follow up questions were asked based on discussions from the answers to the initial interview questions. The interview lasted approximately one and a half hours. Upon completion of the interview, it was transcribed and analyzed for codes and themes.

There are several advantages of conducting a focus group interview. Advantages of conducting a focus group interview are: researchers can quickly assess if the participants have shared views, it is cost effective, participants tend to enjoy them, the interactions among the participants enhance the quality of the data (Krueger, & Casey, 2008), it is a collectivistic rather than an individualistic research method, it is collaborative, and it is empowering (Patton, 2002). It is recommended that teams of two conduct focus groups (Krueger, & Casey, 2008), therefore, the primary researcher and research team member one facilitated the focus group. Questions were asked by both group facilitators. Their varied cultural characteristics should have allowed for ease of the participants with sharing personal information. Utilizing two interviewers also offered multiple perceptions of data, therefore increasing trustworthiness.

### **Researcher's Reflexive Journal**

The participants' reactions towards the questions, toward each other and toward the research team members were recorded in the primary researcher's reflective journal. In the journal, information was written about the participants' communications and actions. The primary researcher utilized the reflective journal to record her own thoughts

about what was happening, feelings that she was having, and ideas about what was occurring or about the phenomenon.

### **Document Review**

The participant's demographic sheets were reviewed and analyzed. This allowed the researcher to gather information about which groups (age groups, minority groups) were represented in this focus group).

### **Data Management**

The focus group interview was recorded on two separate cassette tapes. One was back up tape. The tape was transcribed so that it could be easily read and reviewed for data analysis. The transcription was performed by an outside assigned transcriber. The primary researcher reviewed the tapes following the transcription to compare for accuracy. Then the transcription was given to participants to check for accuracy as member checking.

An outside professional transcriptionist was used for this research study, as it is in many qualitative research studies. This was done to speed up the process of data analysis so that the interviews could be coded soon after they were completed, thus allowing for more accuracy. Utilizing an outside, professional transcriber is considered a limitation of the study. However, the primary researcher was still able to be immersed in the data because the primary researcher was involved in the data collection and analysis in every other step. The primary researcher was a main interviewer and facilitator for the focus group. The primary researcher was further immersed in the data when she coded the data on her own, and then together with the other focus group facilitator to arrive at a

consensus for themes. The primary researcher checked the transcript for accuracy and presented it to focus group members for accuracy as member checking.

Throughout analysis of transcribed data, the researcher constructed the themes in an organized way so that conclusions could be drawn about the data. Through data collection and analysis, various techniques for displaying data such as charts and matrices were utilized. This allowed for connection of ideas and examination of properties.

### **Data Analysis**

Data analysis was conducted in order to narrow the focus and allow key themes to emerge from the data. Analysis focused on coding the data and identifying themes. Information from the transcripts was reduced into codes. The primary researcher and research team member number one read the transcript and analyzed it to elicit themes. Each one separately coded the focus group interview transcript. Next, the two came together to meet and discuss their themes and developed an agreement on the final theme analysis to collaboratively generate codes. The words, phrases, and thematic content that appeared repeatedly were made into codes. The data was categorized and analyzed repeatedly until no new insight emerged (Creswell, 2006).

Thematic analysis was completed as a way to analyze the data. Thematic analysis is a process that allows researchers to translate qualitative information into quantitative data (Miles & Huberman, 1994). It is a process of encoding qualitative information through an explicit code that is a list of themes (a pattern found in the information that describes and organizes the observations and possibly interprets aspects of the phenomenon). Themes can come inductively from the raw data or deductively from prior research and theory (Miles, & Huberman, 1994). The codes were compiled into a



codebook. Next was the interpretive phase of research. “A distinctly phenomenological characteristic of analysis is that the researcher attempts to grasp the essence of the individual’s life experience through imaginative variation.” (Wertz, 2005, p. 172).

### **Data Reduction**

First, information not relevant to the topic was extrapolated. Relevant information was selected and simplified. Open, axial, and selective coding procedures were performed (Strauss & Corbin, 2008). I provided training in coding procedures for research team member one previous to beginning coding procedures.

### **Coding Procedures**

The first step of coding is open coding. In open coding, the phenomenon being explored is described and categorized. Categories are identified and named. It is used to label phenomenon, and it is often done line by line (Strauss & Corbin, 2008). Next, axial coding is used to develop categories. It involves relating codes/categories through inductive and deductive thinking (Strauss & Corbin, 2008). Then, selective coding is a more focused coding, compared to the other types. It entails choosing core category and then relating the other categories to that core category. In selective coding, the researcher, looks specifically for links to the category and integrates categories (Strauss & Corbin, 2008).

An initial set of categories was formed through review of the transcripts, observations/field notes, and document reviews. In open coding, the researcher reviewed the entire transcript to identify the phenomenon and what it is all about. Categories were compared for similarities and differences. Research team member one and the primary researcher discussed the codes and reached a consensus on the codes. The primary

researcher developed a codebook and coded the interview. The primary researcher discussed the codes with the peer debriefer.

After the open coding process was completed, axial coding was utilized. Through the axial coding process, the researcher related codes to each other. Last, the researcher used selective coding to determine a core category. This main category was used as a main theory in which to base the rest. The researcher then used selective coding to connect the categories and explain the main themes.

Comparisons among categories were made until themes emerged. The researcher continued to analyze the data until all of the categories were saturated and no new information was emerging. Coding was utilized to deduce themes and concepts. Observations were utilized to obtain a clear description of the research setting and participants.

### **Trustworthiness and Strategies to Increase Credibility of Findings**

Strategies must be used by researchers to increase the credibility and trustworthiness of research findings. To improve the trustworthiness of this study, research was conducted in an ethical manner; all data was collected following written consent from participants (Appendix B) and in compliance with IRB guidelines. Personal biases and assumptions of the researcher are described above. Patton (2002) reported that a neutral researcher allows for increased credibility. The primary researcher remained open to multiple perspectives and complexities as they emerge. The primary researcher's responses to the research process were monitored by keeping a journal throughout the study, and through peer debriefing as discussion of the work with the dissertation committee and chair. Any biases and pre-judgments of the primary

researcher were continuously monitored and reviewed with an independent observer – the Dissertation Chair. Triangulation of multiple research team members were used through the utilization of a research team consisting of the primary investigator, research team member one, and research team member two.

To be trustworthy, the researcher needs the data to make sense and be accurate. In order to do this, the researcher analyzed the data to the point of redundancy. Member checking was utilized in that the transcribed interviews were provided to the participants to check for accuracy, and changes were made in response to their feedback. The dissertation chair was able to review the data and the research team members all discussed the findings.

In addition, a detailed audit trail was utilized which included journaling, field notes, written communication between research team members, and codebooks showing the code development process. This study utilized an auditor who had experience in qualitative research methods, a doctoral level counselor in a southeastern school system. The auditor was a single, 50 year old, Caucasian female who was selected through the recommendation of other students in the doctoral program who had utilized her as an auditor for their research projects and found her competent and helpful. As the auditor, she provided an ongoing review and evaluation of the study to include trustworthiness of the procedures, audit trail, and outcome.

### **Limitations**

There are several limitations to the current study. Limitations of the qualitative and quantitative portions of the study will now be discussed. A major limitation of this study is that the parent-child relationship was only measured from the parent's

perspective. It is hoped that this study will lay the groundwork for future researchers to add to the study and examine the relationship from the child's perspective, also.

Although there may be differences in parental perceptions and children's perceptions, permission was not granted for this researcher to utilize children receiving treatment at this center, due to concerns over their ability to make an informed decision about participating in this research considering their young ages and mental health issues, and assumed problems with their cooperation in the study due to highly oppositional, defiant, and aggressive behaviors exhibited by most of the children.

Researchers approached the residential center administrator about including child participants in this research study but she indicated potential liability issues and was not particularly favorable to this request. In July 2008, the mental health clinicians at the residential center asked their clients' parents about their willingness to allow their children to participate in a research study. The majority of the parents indicated they would not give their consent if asked. Specifically, parents were uncomfortable with their children discussing the family relationships with researchers. This indicated potential problems gaining enough participants for the study if children were involved.

Additional data gathered at the center indicated a main reason many parents sought treatment for their child was for lying behaviors. This indicated potential problems with validity of data/information if study participants were known to be dishonest. Other behaviors included oppositional and defiant behaviors; temper outbursts; withdrawal; etc., all of which would make for difficult research subjects.

Ultimately, it was determined to be unethical to involve child participants in residential treatment to participate in this research study. The children were in treatment

because they are functioning poorly in their home/family environment. Their parental relationship was a sensitive issue for many of them, as the parent child relationship was such an important relationship in their lives. It would cause them unnecessary distress to have them describe the problems in the relationship. Many of these children were in residential treatment because they displayed aggressive and destructive behaviors when upset. Risking provoking those behaviors in them would not have been outweighed by the gains of this research study.

An additional limitation is that one of the measurements used, the Parent-Child Relationship Inventory was normed on predominantly white parents. This limits the generalizability of the results, as the instrument may not be applicable to those of other cultures.

Also, this research did not examine many attributes or extraneous variables. As a result, the study may be underestimating the relationship that exists because the researcher is not controlling for many covariate issues. This is considered a limitation of this study.

Another limitation is the format of the self-report questionnaire. Knowledge obtained through self-report is limited to the perception of individuals and limits what can be learned about the family as a system. The study was gathering information on the parents' perception of change in the parent-child relationship, rather than actual change in the relationship. Perceptions are always different than reality.

A further limitation is that those who have lived in western culture are targeted by the Index of Parental Attitudes (IPA) for use. The psychometric research that has been conducted to validate the IPA has relied predominantly on those who have lived in the

United States for a very long time. Therefore, we cannot be sure the IPA will perform in the same manner when used with people from markedly different cultures, and therefore may not be suitable for use with individuals from different cultures, which also limits the general applicability of these research findings.

Further, the fact that the children in this study were residing at the residential center and not with their parents while the parent-child relationship was being measured may be a limitation of this study. However, the children in this facility were in daily contact with their parents by telephone, had weekly hour long family counseling sessions, participated in two hour weekend parent-child interaction activities, and the children spent the weekends at home with their parents. There were monthly parent-child events, and the children went home for spring break and other holiday breaks. Additionally, the parents typically sent the children letters and picked them up about once a week for outside appointments. So, while they were in this residential treatment facility, they were still having a great deal of contact with their families.

An additional limitation of the study is that the sample was limited in number and diversity. Participants were predominantly male and from one small residential facility, which limits the ability to generalize these quantitative findings to a larger population. The qualitative portion of the research design did not yield a statistically significant understanding of the phenomenon of the experience of parents having a child receiving residential mental health treatment and that experience within the parent-child relationship. Thus, the generalizability of this study is limited. The generalizability of the study is also limited because the sample of participants was from only one residential center. However, the goal of this study was to provide data to allow additional depth of

insight, rather than externally generalize to a larger population. The data was provided in thick, rich, description in order to increase the usefulness of this study. Other researchers could use this study as a basis to attempt to duplicate the findings by repeating it at other centers. If focus groups could be conducted at more than one residential treatment center, results may be more generalizable.

Further, the sampling method that was utilized may have produced a biased sample. Studying only those who agree to participate in the study does not allow researchers to examine the experiences of those who do not agree to participate. Agreeing to participate may produce some bias related to the motivation to participate in the research study. If data could be collected from both groups, different data may be gathered. However, it was not possible or ethical to research participants without their consent.

Also, potential researcher bias is a limitation of this study. This is a limitation of all qualitative research studies. This was addressed through the use of peer debriefing, journaling, identifying and discussing those biases and how they may affect the research study, the researcher remaining aware of those biases, and utilizing a research team and auditor.

In addition, there are limitations to using a focus group interview in research. Limitations of utilizing a focus group interview format include: participants may be unwilling to disclose certain things in an effort to maintain appearances, especially if their view differs from the rest of the group's view; each participant has less time to respond in a group setting; only a limited number of questions can be asked, and the interviewers must have group facilitations skills (Krueger, & Casey, 2008). The two

interviewers in this study had 20 years combined experience with group facilitation and were trained in group facilitations skills. It is hoped that their facilitation skills allowed participants to feel comfortable disclosing alternate points of view. Confidentiality cannot be ensured to the group participants (Krueger, & Casey, 2008). Therefore, group facilitators ensured they discussed this clearly with participants at the beginning of the group and before participants gave their consent. A further limitation of the focus group format is that it takes place outside natural social interaction settings (Patton, 2002). To adjust for that, this focus group was built into the pre-existing parent support group that was already meeting. A final limitation noted by Patton, 2002, is that in focus groups interviews, major themes can be identified, but not subtle differences.

As previously stated, the use of a professional transcriber is also a limitation of the study, however the primary researcher was still able to be immersed in the data. The advantages of using a focus group interview format are: researchers can quickly assess if the participants have shared views, it is cost effective, participants tend to enjoy them, the interactions among the participants enhance the quality of the data (Krueger, & Casey, 2008), it is a collectivistic rather than an individualistic research method, it is collaborative, it is embowering (Patton, 2002); and the primary researcher for this study believed the advantages for using this format highly outweigh the disadvantages; and it is held in a social context in which the participants are able to consider their own views in the context of other persons' views vantages.

A further limitation of this study is the demographic characteristics of the participants. They were all from a specific area in the South Eastern United States that the residential facility serves. Having a geographical limitation may have provided a



limited understanding of the phenomenon of the experience of parents having a child receiving residential mental health treatment and that experience within the parent-child relationship. However, many of the participants were originally from other areas of the country.

Another notable limitation of the study is the children's point of view was not examined. When children are placed in residential treatment away from their family home, the family relationships are usually strained. It can be painful for children to discuss these relationships and the benefit of the knowledge gained through this research does not outweigh the harm caused to these children through the emotional reactions that could have potentially occurred when having them discuss their strained parental relationships with a stranger for research purposes. Also, parents are not eager to give their consent for their child to discuss them. As the children in residential treatment exhibit aggressive, defiant, and lying behaviors regularly, they do not make appropriate interview subjects from which to gather trustworthy data.

A further limitation of the study was evolution of the program. The quantitative data in this study was collected between August 2008 and January 2010. The qualitative data for this study was collected in June 2010. During that time, some changes did take place at the residential center, causing treatment to evolve. The largest change notable is staff turnover. One behavioral specialist ceased working at the center, as well as one weekend staff member. Also, a teacher and mental health clinician left their jobs at the facility. Each of these staff members was replaced. The programmatic changes were minimal, because a major goal of the facility is to provide stability and clear expectations for the children. An aim of the center over the six months in between testing grew to

include using mindfulness and relaxation techniques with the children, and to use more interaction in group counseling. Staff members were encouraged to use activities such as music and movement or games rather than watching guidance lessons through movies or completing packets of worksheets. The programming did change in the evenings so that the children were provided with an opportunity to journal about their days, however this did not ever get well monitored or enforced. The changes that occur during the evolution of the program leave no room for control over treatment fidelity. However, the residential program is always going to evolve and it continued to evolve while the qualitative data was being collected for a year and a half. When researchers do a study for a long period of time, it has to be expected that changes will take place. The same research conducted over short amounts of time would not provide accurate data because children would not be in treatment long enough to have treatment effects. Further, it was effective to use qualitative data in addition to the previously collected quantitative data, because the qualitative data was adding depth and richness to the information that was already gathered through quantitative means. It was also able to address issues that could not be discovered using only quantitative data, such as those not specifically asked about in the test questions. Alternative explanations for the findings were considered and examined. Also, parents possibly gave socially desirable answers to the focus group questions, given the location of the interview being at the residential facility, and the presence of a staff member from that facility.

### **Delimitations**

The Parent-Child Relationship Inventory does provide a social desirability scale, in order to alert the researcher to responses that may not be considered accurate. While

this research was conducted using a small sample, it provides direction for future research and identifies opportunities for expansion with larger, more generalizable samples. Other delimitations include: the sample only comes from one agency, during one time period.

### **Summary**

In summary, this research study contained an additional component of a qualitative nature. A phenomenological focus group interview was conducted. Purposeful sampling was utilized, with the criterion of parents that have a child receiving residential mental health treatment. Participants were recruited from the mandatory parenting group at a residential treatment facility. Two researchers with varied cultural characteristics asked about 6 parents general questions about the experience of having a child in residential mental health treatment and about that experience within their parent-child relationship. Data was analyzed for themes by two researchers; first individually, then together. All necessary steps to maintain participants' confidentiality and safety were taken, and the study was reviewed by the ODU IRB before it could be initiated. The essence of the experience of a parent with a child receiving residential mental health treatment services and how he or she perceives it within the parent-child relationship was examined in depth.

## **CHAPTER FOUR**

### **FINDINGS AND INTERPRETATIONS**

The quantitative part of this study investigated the parent's perception of the association between children's residential mental health treatment and the parent-child relationship. The variables that were examined include discourse in the parent child relationship as measured by the IPA; parental support, satisfaction with parenting, parental involvement, communication, and limit setting aspects of the parent child relationship as measured by the PCRI; and residential treatment. The demographic variables of the participants and their families were examined, including age, gender, ethnicity, income, siblings, diagnoses, treatment history, relationship status, and length of time in treatment. This chapter reports the results of the research study, beginning with a summary of the demographic information about the participant families. Instrument demographics and results of the tests scores pre and post residential treatment are presented. The results are presented for the statistical analyses used to test each hypothesis associated with the specific research questions, therefore answering each research question. Tables are presented as well as discussion.

#### **Characteristics of the Sample**

The population of this study consisted of parents of children receiving residential mental health treatment in an Eastern U.S. residential facility. The sample was convenience, and criterion based. The criterion was parents with children receiving residential treatment. The parents of all children receiving residential services at the facility between August 2008 and January 2010 completed the test instruments for clinical treatment purposes. The program administrator then gave permission for the

data to be used for this research study as archival data. The assessments were distributed to parents by the clinicians at the residential center when the child entered treatment and again when the child was discharged from treatment. Seventy cases were utilized for study (70 children in residential treatment). Additionally, 103 parents completed valid assessments before and after their child's treatment.

A demographics sheet was completed on each family in the study (see Appendix D). The following demographics are provided for the parents who completed the assessments, their children who were receiving residential treatment in this study, and the family as a whole. Some information comes from examination of clinical records, and other information was provided by parents on the assessment forms.

Participants were asked to state the gender of their child who was in treatment on the assessments. Descriptive data for the gender of the children who received treatment are presented in Table 1.

**Table 1**  
***Frequency Distribution by Gender of Participants' Children in Residential Treatment***

Gender	Frequency	Percent
Male	54	77.1%
Female	16	22.9%
Total	<i>N</i> = 70	100.0%

The frequency distribution for the gender of the children in treatment indicates that male (77.1%) was the primary gender type.

Participants were also asked to state the age of their child in treatment on the assessments. Descriptive data for the ages of the children who received treatment are presented in Table 2.

**Table 2**  
***Frequency Distribution by Ages of Participants' Children in Residential Treatment***

Ages	Frequency	Percent
Age 5	03	04.3%
Age 6	08	11.4%
Age 7	09	12.9%
Age 8	13	18.6%
Age 9	08	11.4%
Age 10	06	08.6%
Age 11	10	14.3%
Age 12	09	12.9%
Age 13	04	05.7%
Total	<i>N</i> = 70	100.0%

The frequency distribution for the ages of the children in residential treatment indicates that several ages were well represented; with no one age representing a majority of the children. Ages ranged from 5 to 13.

Chart records were examined to identify the ethnicity of the participant's child in treatment. Descriptive data for the ethnicity of the children who received treatment are presented in Table 3.

**Table 3**  
***Frequency Distribution by Ethnicity of Participants' Children in Residential Treatment***

Ethnicity	Frequency	Percent
Caucasian	40	57.1%
African American	19	27.1%
Biracial	07	10.0%
Hispanic	02	02.9%
Asian	01	01.4%
German	01	01.4%
Total	<i>N</i> = 70	100.0%

The frequency distribution indicates the majority of children receiving treatment were Caucasian (57.1%). African American was the second most common ethnicity represented (27.1%).

Chart records were examined by the primary researcher to detect each participant family's income. The income was divided into levels. Parents making under \$30,000 per year were labeled with a *low* income. Parents who stated their income as between \$30,000 and \$60,000 per year were labeled with a *medium* income, and parents who described their income as over \$60,000 per year were given the *high* income label. Descriptive data for the family income are presented in Table 4.

**Table 4**  
***Frequency Distribution by Family Income of Participants***

Income Level	Frequency	Percent
Low Income	19	27.1%
Medium Income	18	25.7%
High Income	11	15.7%
None Reported	22	31.4%
Total	N = 70	100.0%

The frequency distribution for each participant's family income indicated that several areas were well represented. Participants who chose not to report their income were the most frequently represented with 22 participants which made up 31.4% of the participants.

Chart records were examined to determine how many siblings the child receiving treatment had in the home. Descriptive data for the number of siblings in the homes of the children who received treatment are presented in Table 5.

**Table 5**

***Frequency Distribution by Number of Siblings in the Home of the Participants' Child in Residential Treatment***

Number of Siblings	Frequency	Percent
None	17	24.3%
One	29	41.4%
Two	16	22.9%
Three	04	05.7%
Four	04	05.7%
Total	<i>N</i> = 70	100.0%

The frequency distribution indicated several numbers of siblings were well represented; with no one number representing a majority of participants. The category of children having only one other sibling in the home was the most frequently represented with 29 children represented which made up 41.4% of the children receiving treatment.

Chart records were examined by the primary researcher to determine the participants' romantic relationship status. Descriptive data for the status of the relationship of the parents who completed the assessments for this study are presented in Table 6.

**Table 6**

***Frequency Distribution by Participants' Partner Relationship Status***

Relationship Descriptor	Frequency	Percent
No Romantic Relationship	20	19.4%
Stable Romantic Relationship	58	56.3%
Unstable Romantic Relationship	25	24.3%
Total	<i>N</i> = 10370	100.0%

The frequency distribution for the participant's romantic relationship status indicated all romantic relationship descriptors were well represented, with no one status representing a majority of participants. The most frequently occurring category represented was having a stable romantic relationship with 35 parents represented which made up 30% of participants.



The primary researcher examined the children's charts to determine which diagnoses they were given when they were first admitted to the residential treatment program. Each of the children participating in this study and receiving treatment at the residential facility was given a mental health diagnosis by their outside community therapist before they could be admitted for treatment. Descriptive data for the type of diagnoses the children who received treatment were given at the time of their admission to residential care are presented in Table 7. Children could be given more than one diagnoses upon admission.

**Table 7**  
***Frequency Distribution by Admission Diagnoses of the Participants' Children in Residential Treatment***

Diagnosis	Frequency	Percent
Attention Deficit Hyperactivity Disorder	40	34.5%
Oppositional Defiant Disorder	17	14.7%
Mood Disorder	35	30.2%
Post Traumatic Stress Disorder	05	04.3%
Asperger's Disorder	09	07.8%
Anxiety Disorder	04	03.4%
Other	06	05.2%
Total	<i>N</i> = 116	100.0%

The frequency distribution for the type of diagnoses the children were given when they were first admitted to residential treatment indicates that several diagnoses were represented, with ADHD (represented 40 children making up 34.5% of the diagnoses) and Mood Disorder (represented 35 children making up 30.2% of the diagnoses) being the most common among the respondents.

The children's charts were again examined by the primary researcher in order to find the number of diagnoses the children were given when first admitted for treatment. Descriptive data for the number of diagnoses the children who received treatment were given at the time of their admission to residential care are presented in Table 8.

**Table 8**  
***Frequency Distribution by Number of Admission Diagnoses of Participants' Children in Residential Treatment***

Number	Frequency	Percent
One	21	30.0%
Two	27	38.6%
Three	20	28.6%
Four or more	02	02.9%
Total	<i>N</i> = 70	100.0%

The frequency distribution for the number of diagnoses the children were given when they first entered residential treatment indicates no majority, with several numbers well represented. The most frequently represented number of diagnoses given was two with 27 children represented making up 38.6% of the children receiving treatment.

Charts were examined by the primary researcher further, in order to determine the treatment history of the children, specifically whether they had been in residential treatment before this time, and if so, how many times previously. Descriptive data for the number of times the children were previously treated in residential placements before their admission to this residential facility are presented in Table 9.

**Table 9**  
***Frequency Distribution by Residential Treatment History of Participants' Children***

Residential Treatment	Frequency	Percent
None	67	95.7%
One	03	04.3%
Two	00	00.0%
Three	00	00.0%
Four or more	00	00.0%
Total	<i>N</i> = 70	100.0%

The frequency distribution for the children's residential treatment history indicated the majority of children in the study had no past history of participating in residential treatment before they were admitted to this residential treatment facility.

Sixty- seven children (95.7%) in this study had no past history with residential treatment. Only three children (4.3%) had been treated in a residential program once before.

The primary researcher continued to examine the children's charts to determine treatment history; in this case to describe whether the child had ever been to the psychiatric hospital for treatment, and if so, how many times. Descriptive data for the number of times the children receiving treatment were previously admitted to psychiatric hospitals are presented in Table 10.

**Table 10**  
***Frequency Distribution by Psychiatric Hospital Treatment History of Participants' Children in Residential Treatment***

Psychiatric Hospitalizations	Frequency	Percent
No admissions	61	87.1%
One admission	06	08.6%
Two admissions	01	01.4%
Three admissions	02	02.9%
Four or more admissions	00	00.0%
Total	<i>N</i> = 70	100.0%

The frequency distribution for the children's psychiatric hospital treatment history indicated the majority of children, 87.1% or 61 of the children studied had not ever been admitted for treatment in the psychiatric hospital. The remainder of the children (9) making up 12.9% had between 1 and 3 admissions to psychiatric hospitals before entering this residential treatment facility.

Finally, the records were examined again by the clinician for treatment history that described how many times the child had been in outpatient counseling before coming into residential treatment. Descriptive data for the number of times the children receiving treatment attempted counseling in an outpatient setting before their admission to this residential treatment center are presented in Table 11.

**Table 11**

***Frequency Distribution by Outpatient Treatment History of Participants' Children in Residential Care***

Number of Treatments	Frequency	Percent
None	22	31.4%
One	22	31.4%
Two	19	27.1%
Three	03	04.3%
Four or more	04	05.7%
Total	<i>N</i> = 70	100.0%

The frequency distribution for the outpatient treatment history of the children in residential treatment indicated no one majority number of counseling attempts. However, the most frequently represented were a history of no outpatient counseling attempted before residential treatment, or a history of outpatient counseling being tried one time before residential treatment. Each category was represented by 22 children and each made up 31.4% of the children being studied.

**Data Screening and Diagnostics**

Before conducting analysis of the research questions, data screening, recoding and diagnostics was conducted. Since the data were archival, it had previously been scored. The researcher checked scores for accuracy. The Index of Parental Attitudes (Hudson, 1997) had items that required reverse scoring. The researcher checked that the items had been reverse scored.

The Parent Child Relationship Inventory had 2 validity scales, The Social Desirability Scale, and the Inconsistency Indicator. The PCRI assessments were each scored on those scales and the cases that had invalid scores on those scales were eliminated from the study.

The score on the PCRI was obtained by transferring the number circled by the parent for each item to its corresponding box and then adding up the values for each

column. Those sums were added to get the final scale raw scores. The raw scores for each scale had then been transferred to the PCRI Profile Form and plotted. The scores were then converted to normalized *t*-scores with a standard deviation of 10 and a mean of 50.

The IPA was scored as one composite test score. Test scores were computed by first reverse scoring using the computation  $X = K - Y + 1$  where *X* was the reverse scored value and *Y* was the original score provided by the respondent. *K* was the largest item response permitted. Ten items were reverse scored; items 2, 3, 5, 8, 2, 14, 15, 16, 21, and 24. Next, all items were summed. The number of correctly completed items was subtracted from the sum. That number was then multiplied by 100. The result was then divided by (the number of completed items) multiplied by (*K* - 1). Once the data were screened and diagnosed, scores could be utilized to determine the findings for this study.

### **Overall Findings**

Scores on the Index of Parental Attitudes and the Parent-Child Relationship Inventory were utilized in this study to measure parental perceptions of the association between residential treatment and the parent-child relationship.

Based on the scoring matrix, lower scores on the IPA represent more positive parental attitudes and less distress in the parent-child relationship. Higher scores represent greater problems in the parent child relationship. Higher scores indicated greater problems with the parent-child relationship. Scores on this instrument were a true ratio value. The IPA scores indicate the level of severity of discord in the parent-child relationship, and the magnitude of personal and social functioning problems in that relationship. The PCRI was scored as 5 scales providing five separate subscale scores to

assess the parent-child relationship according to strengths and weaknesses in the scale areas. Scores in each scale could range from 0 to 100. Based on the scoring manual higher scores on the PCRI scales represent good parenting skills /more positive levels or increased levels of the construct being measured (support, satisfaction, involvement, communication, limit setting). Lower scores on the PCRI indicate poor parenting skills.

Scores on the five scales of the PCRI and scores on the total IPA score were utilized in this study to measure parental perceptions of the associations between children's residential mental health treatment and the parent-child relationship.

### **Tests of Hypotheses**

#### **Research Question**

The study investigated the following broad research question: Is there a significant change in the parent-child relationship for children ages 5-13 years old with emotional and behavioral disorders who have received residential treatment?

*T*-tests were utilized to determine variance in the scores before residential treatment and after residential treatment. The results of the six statistical analyses are outlined below. A statistical significance level of  $p < .05$  was sought.

Research question 1 stated, Is there a significant change in perceptions of the parent-child relationship, as measured by the Index of Parental Attitudes at post-residential treatment for parents of children ages 5 to 13 with emotional and behavioral disorders?

#### **Test of Hypothesis 1**

Hypothesis 1 stated that there will be a significant difference in parental attitudes post-treatment as evidenced by a *t*-score exceeding the critical *t*-value for the respective

sample size. There will be significantly lower scores post-treatment, which indicate more positive parental attitudes toward children.

### **IPA Test scores.**

The descriptive statistics of the IPA tests that were administered pre-residential treatment included a mean of 27.8 and a standard deviation of 11.5. There were a total of 103 scores, ranging from 4.6 to 57.3. The IPA test scores administered post-residential treatment ranged between 3.3 and 57.0 with a mean of 18.8 and a standard deviation of 10.4. Possible Scores for this scale are 0 to 100. A total of 103 test scores were analyzed.

**Relationship between child's residential treatment and parental attitudes.** To explore the possible relationship between the parental attitudes/the amount of distress in the parent child relationship and the independent variable child's residential mental health treatment, the means of the dependent variable parental attitudes (as evidenced by scores of the IPA) were compared from assessments administered before the child's residential mental health treatment and after the child's residential mental health treatment. Inspection of the graph for the Index of Parental Attitudes at both testings show it appears to be approximately a normal distribution (kurtosis = -1.99, 1.881, skewness = .212, 1.184). On average, parents reported significantly less discord in the parent-child relationship after their child attended residential treatment ( $M = 18.8$ ,  $SD = 10.4$ ) as compared to before entering treatment ( $M = 27.8$ ,  $SD = 11.5$ ),  $t(102) = -7.142$ ,  $p < .001$ ,  $r^2 = .11$ . This indicates statistical significance and a small effect size.

Research question 2 stated, Is there a significant change in perceptions of the parent-child relationship, as measured by the Parent-Child Relationship Inventory scales,

at post-residential treatment for parents of children ages 5 to 13 with behavioral and emotional disorders? Research question 2 was broken into parts for further analysis.

The first part of research question 2 stated, Is there a significant change in the level of support a parent perceives to be present, as measured by the Parental Support scale of the PCRI completed by the parents of children ages 5-13 with behavioral and emotional disorders at post-residential treatment?

### **Test of Hypothesis 2**

Hypothesis 2 stated that there will be a significant difference in level of support post-treatment as evidenced by a *t*-score exceeding the critical *t*-value for the respective sample size. There will be significantly higher scores post-treatment, which indicate the parents feel more supported and engage in more supportive activities.

**PCRI Parental Support Scale.** The Parent Support scale consisted of 9 items. Each participant received a score for the Parental Support subscale that indicated his or her level of emotional and social support received. The PCRI scale Parental Support test scores administered pre-residential treatment admission ranged between 25 and 70 with a mean of 45.8 and a standard deviation of 8.5. Possible Scores for this scale are 0 to 100. A total of 103 test scores were analyzed.

The PCRI scale Parental Support test scores administered post-residential treatment admission ranged between 19 and 74 ( $M=50.2$ ,  $SD=9.8$ )( $N=103$ ).

**Relationship between child's residential treatment and parental support.** To explore the possible relationship between the parental perceptions of their amount of support and the independent variable child's residential mental health treatment, the means of the dependent variable support (as evidenced by scores of the Support scale of



the PCRI) were compared from assessments administered before the child's residential mental health treatment and after the child's residential mental health treatment.

Inspection of the graph for Parental Support at both testings show it appears to be approximately a normal distribution (kurtosis =.931, 1.057, skewness=.172, -.457).

On average, parents reported significantly greater support from the treatment facility after their child attended residential treatment ( $M = 50.16$ ,  $SD = 9.80$ ) as compared to before entering treatment ( $M = 45.84$ ,  $SD = 8.55$ ),  $t(102) = 3.971$ ,  $p < .001$ ,  $r^2 = .56$ . This indicates statistical significance and a large effect size.

An additional part of research question 2 stated, Is there a significant change in the degree of satisfaction with parenting that a parent perceives is present in the parent-child relationship, as measured by the Satisfaction with Parenting scale of the PCRI completed by the parents of children ages 5-13 with behavioral and emotional disorders at post-residential treatment?

### **Test of Hypothesis 3**

Hypothesis 3 stated that there will be a significant difference in degree of satisfaction post-treatment as evidenced by a  $t$ -score exceeding the critical  $t$ -value for the respective sample size. There will be significantly higher scores post-treatment, which indicate the parents feel more satisfied with parenting their child.

**PCRI Satisfaction with Parenting Scale.** The Satisfaction with Parenting scale consisted of 10 items. Each participant received a score for the Satisfaction with Parenting subscale that indicated his or her level of fulfillment derived from being a parent. The PCRI test scale Satisfaction with Parenting scores administered to the children's parents pre-residential treatment admission ranged from 23 to 68 ( $M = 47.8$ ,

$SD=9.8$ ;  $N=103$ ). The PCRI test scale Satisfaction with Parenting scores administered to the children's parents post-residential treatment admission ranged from 24 to 68 ( $M=49.7$ ,  $SD=8.3$ ;  $N=103$ ).

**Relationship between child's residential treatment and parental satisfaction.**

To explore the possible relationship between the parental perceptions of their satisfaction with parenting and the independent variable child's residential mental health treatment, the means of the dependent variable satisfaction with parenting (as evidenced by scores of the Satisfaction with Parenting scale of the PCRI) were compared from assessments administered before the child's residential mental health treatment and after the child's residential mental health treatment. Inspection of the graph for the PCRI Parental Satisfaction with Parenting at both testings show it appears to be approximately a normal distribution (kurtosis =.001, .528 skewness=.312, .054). On average, parents reported significantly greater satisfaction with parenting after their child attended residential treatment ( $M= 49.7$ ,  $SD=8.3$ ) as compared to before entering treatment ( $M= 47.8$ ,  $SD= 9.8$ ),  $t(102)= 2.096$ ,  $p < .001$ ,  $r^2= .22$ . This indicates statistical significance and a small effect size.

The next part of research question 2 stated, Is there a significant change in the amount of parental involvement that a parent perceives is present in their parent-child relationship, as measured by the Parental Involvement scale of the PCRI completed by the parents of children ages 5-13 with behavioral and emotional disorders at post-residential treatment?

### Test of Hypothesis 4

Hypothesis 4 stated that there will be a significant difference in parental involvement post-treatment as evidenced by a *t*-score exceeding the critical *t*-value for the respective sample size. There will be significantly higher scores post-treatment, which indicate greater parental knowledge of the child and an increase in the time the parent is spending involved with the child.

**PCRI Parental Involvement Scale.** The Parental Involvement scale consisted of 14 items. Each participant received a score for the Parental Involvement subscale that indicated his or her level of interaction with and knowledge of his or her child. The PCRI test scale Parental Involvement scores administered to the children's parents pre-residential treatment admission ranged from 15 to 65 ( $M=39.9$ ,  $SD=11.2$ ;  $N=103$ ). The PCRI test scale Parental Involvement scores administered to the children's parents post-residential treatment admission ranged from 18 to 72 ( $M=45.1$ ,  $SD=10.1$ ;  $N=103$ ).

### **Relationship between child's residential treatment and parental involvement.**

To explore the possible relationship between the parental perceptions of their involvement with the child and the dependent variable child's residential mental health treatment, the means of the dependent variable involvement (as evidenced by scores of the Involvement scale of the PCRI) were compared from assessments administered before the child's residential mental health treatment and after the child's residential mental health treatment. Inspection of the graph for the PCRI Parental Involvement scale at both testings show it appears to be approximately a normal distribution (kurtosis = .100, .622, skewness = .218, -.076). On average, parents reported significantly greater parental involvement with their children after their child attended residential treatment ( $M= 45.1$ ,

$SD= 10.1$ ) as compared to before entering treatment ( $M=39.9$ ,  $SD=11.2$ ),  $t(102) = 4.458$ ,  $p < .001$ ,  $r^2 = .16$ . This indicates statistical significance and a small effect size.

An additional part of research question 2 stated, Is there a significant change in the communication in a parent child relationship, as measured by the Communication scale of the PCRI completed by the parents of children ages 5-13 with behavioral and emotional disorders at post-residential treatment?

### **Test of Hypothesis 5**

Hypothesis 5 stated that there will be a significant difference in communication post-treatment as evidenced by a  $t$ -score exceeding the critical  $t$ -value for the respective sample size. There will be significantly higher scores post-treatment, which indicate more positive communication from the parent to the child.

**PCRI Communication Scale.** The Communication scale consisted of 9 items. Each participant received a score for the Communication subscale that indicated his or her level of perception of how effectively he or she communicates with his or her child. The PCRI test scale Communication scores administered to the children's parents pre-residential treatment admission ranged from 10 to 60 ( $M=38.3$ ,  $SD=9.3$ ;  $N=103$ ). The PCRI test scale Communication scores administered to the children's parents post-residential treatment admission ranged from 24 to 62 ( $M=43.0$ ,  $SD=7.4$ ;  $N=103$ ).

**Relationship between child's residential treatment and parental communication.** To explore the possible relationship between the parental perceptions of their communication with the child and the independent variable child's residential mental health treatment, the means of the dependent variable communication (as evidenced by scores of the Communication scale of the PCRI) were compared from

assessments administered before the child's residential mental health treatment and after the child's residential mental health treatment. Inspection of the graph for the PCRI Communication scale at both testings show it appears to be approximately a normal distribution (kurtosis =.421, .257, skewness=.069, -.069). On average, parents reported significantly more positive communication with their children after their child attended residential treatment ( $M= 43.0$ ,  $SD=7.4$ ) as compared to before entering treatment ( $M= 38.3$ ,  $SD=9.3$ ),  $t(102)= 4.809$ ,  $p < .001$ ,  $r^2= .09$ . This indicates statistical significance and approaching a small effect.

The last part of research question 2 stated, Is there a significant change in the limit setting by a parent in a parent-child relationship, as measured by the Limit Setting scale of the PCRI completed by the parents of children ages 5-13 with behavioral and emotional disorders at post-residential treatment?

### **Test of Hypothesis 6**

Hypothesis 6 stated that there will be a significant difference in limit setting post-treatment as evidenced by a  $t$ -score exceeding the critical  $t$ -value for the respective sample size. There will be significantly higher scores post-treatment, which indicate greater limit setting by the parent.

**PCRI Limit Setting Scale.** The Limit Setting scale consisted of 12 items. Each participant received a score for the Limit Setting subscale that indicated his or her level of experience disciplining his or her child. The PCRI test Limit Setting scale scores administered to the children's parents pre-residential treatment admission ranged from 26 to 72 ( $M=42.1$ ,  $SD=6.2$ ;  $N=103$ ). The PCRI test Limit Setting scale scores administered

to the children's parents post-residential treatment admission ranged from 29 – 74 ( $M=48.2$ ,  $SD=6.5$ ;  $N=103$ ).

#### **Relationship between child's residential treatment and parental limit setting.**

To explore the possible relationship between the parental perceptions of their appropriate limit setting with the child and the independent variable child's residential mental health treatment, the means of the dependent variable Limit Setting (as evidenced by scores of the Limit Setting scale of the PCRI) were compared from assessments administered before the child's residential mental health treatment and after the child's residential mental health treatment. Inspection of the graphs for the PCRI Limit Setting scale at both testings showed it appears to be approximately a normal distribution (kurtosis =5.508, 2.621, skewness=1.066, .341). On average, parents reported significantly greater limit setting with their children after their child attended residential treatment ( $M= 48.2$ ,  $SD=6.5$ ) as compared to before entering treatment ( $M= 42.1$ ,  $SD=6.2$ ),  $t(102) = 9.002$ ,  $p < .001$ ,  $r^2 = .17$ . This indicates statistical significance and a small effect size.

The results of this quantitative portion of the study indicated, through the tests of these hypotheses that there were significant changes on all scales. On average, parents were found to have the perceptions that after their child attended residential treatment, they had less discord in the parent-child relationship, they were more supported in parenting, they were more satisfied with parenting, they communicated more with their child, they were more involved with their child, and they set more limits as a parent as compared to before their child entered treatment. These results are expanded on in greater depth through the qualitative portion of the study below.

### **Qualitative Research Findings**

This portion of the chapter corresponds to the qualitative portion of the research design. Qualitative data was collected and analyzed in addition to the quantitative data in order to add more detail and depth to the study. The purpose of this part of the chapter is to present the findings that emerged from the participants' responses to the research question: What is the essence of the experience for a parent to have a child in residential mental health treatment, and how do parents perceive it to be experienced within the parent-child relationship?

### **Data Collection and Analysis Procedures**

The procedures for data collection and analysis will now be described. Purposeful, criterion based sampling was utilized to identify parents who currently had children participating in residential treatment at the facility in the Eastern U. S. at which the archival data was collected for the earlier portion of this study. Parents who had children currently being treated in the residential program were required to attend parent support group meetings each Monday evening. The primary researcher approached the administrator of the residential facility and obtained permission to conduct the focus group interview utilizing the parent support group for participants. Next, the primary researcher met with the parent support group facilitator for coordination.

### **Participant Selection**

The research team attended the parent support group meeting one Monday and explained the purpose and risks of the study. The research team then asked for six volunteers, requesting that they get a mix of genders, ethnicities, and length of time their children had been in the residential treatment program. Parents began standing up to

volunteer, individually. This method provided access to a variety of parents, because parents could see who had already volunteered before deciding if they should volunteer. A total of 6 parents volunteered to participate in the focus group interview.

After the participants agreed to take part in this research project, the research team walked them to a family therapy room next door where they were offered snacks and beverages. Prior to conducting the focus group interview, the primary researcher reviewed the purpose of the study and the possible risks involved. The primary researcher discussed confidentiality and the limits of confidentiality in groups. Next, the participants were asked to sign a consent form (see Appendix B). This was reviewed with them and they were offered a copy to take with them.

### **Participant Group Profile**

Demographic sheets (see Appendix D) were then completed by each parent in the focus group, providing information on themselves and their child in residential treatment. All of the participants met the sampling criteria of having a child in residential treatment at that facility. I will now discuss the demographics of the parents of the children receiving residential treatment, who participated in the focus group interview.

First, the participants were asked to state their gender. The focus group interview participants' genders were split equally between males, 3 participants (50%) and females, 3 participants (50%).

Next, the participants were asked to state their age. Half (3) of the focus group participants were ages 46 to 52 (50%). One focus group participant (16.7%) fell into the age category of 39-45 years old. None of the focus group participants were 32 to 38



years old. The other 2 participants (33.3%) had ages ranging between 25 and 31 years old.

Next, the participants were asked to describe their ethnicity. Four of the participants or 66.7% describe themselves as Caucasian. One of the participants (16.7%) described himself as African American. Also, one of the participants (16.7%) described himself as Biracial/Multicultural.

The focus group participants were also asked to describe the status of their romantic relationships. Four of the focus group participants (66.7%) reported they were currently in a mostly stable romantic relationship. One participant (16.7%) was currently in a strained/unstable romantic relationship. Similarly, one participant (16.7%) was currently not in a romantic relationship.

Next, the participants of the focus group were asked to state their annual household income level. The categories were divided into: low income (under \$30,000), mid-level income (\$31,000 - \$60,000), and high income (\$61,000 and higher) levels.

There was no one majority for the income level of the participants. However, the focus group participants were represented most frequently by middle (2 participants making up 33.3%) and high income levels (2 participants making up 33.3%). One participant (16.7%) reported a low income level. One participant (16.7%) did not state their income level.

The information I will now discuss contains the demographic information that represents the children participating in residential treatment, whose parents participated in the focus group interview.

The participants were asked to state the gender of their child in residential treatment.

The focus group participants had children in the residential treatment program whose primary gender were male (66.7%). Only 33.3% (n= 2) of the participants' children in treatment were female.

The participants were then asked to state the age of their child in residential treatment. The majority of the focus group participants (four people) had children who were 12 years old (66.7%) at the time they received residential treatment, although the center provided treatment for children ages 5-12. The small age range of the children was not expected. One participant (16.7%) had a child in treatment who was 10 years old. Also, one participant (16.7%) had a child receiving treatment who was 11 years old.

The participants were also asked to describe the ethnicity of their child who was receiving residential treatment. Half (50.5%) of the participants' children in the residential treatment program were Caucasian, indicating 3 participants' children in this study. The remaining treated children of the participants were Biracial/Multicultural (33.3%, representing 2 children) or African American (16.7%, representing 1 child in the study).

Next, the participants were asked to state the number of siblings their child being treated in residential treatment had in the home. Reportedly, 16.7% of the children who received treatment had no siblings residing in the home. The majority, or 83.4% of the children who received treatment had one sibling residing in the home.

Then, the participants were asked to state their child's diagnoses. The most common diagnoses of the focus group participant's children in residential treatment were

Oppositional Defiant Disorder (21.43%) and Mood Disorder/Depression/Bipolar Disorder (21.43%). The next most common Diagnoses given to the children of the focus group participants upon admission to residential treatment were Attention Deficit Hyperactivity Disorder (14.29%) and Aspergers/Autism Disorders (14.29 %). Other children had diagnoses of Anxiety Disorders (7.1%), and Obsessive Compulsive Disorder (7.1%).

Children were able to receive more than one diagnosis upon admission to the program.

Reportedly, 33.3% of the children who received treatment were given one diagnosis at the time of their admission to residential care. Participants reported 33.3% of the children who received treatment were given two diagnoses at the time of their admission to residential care. None (00.0%) of the children who received treatment were given three diagnoses at the time of their admission to residential care. Last, 33.3% of the children who received treatment were given four or more diagnoses at the time of their admission to residential care.

Finally, the participants were asked to describe their child's treatment history. First, participants were asked to describe any previous history their child had in residential treatment. Reportedly, 66.7% of children were never treated in residential placements before their admission to this residential facility. Participants reported 33.3% of children were previously treated one time in a residential placement before their admission to this residential facility. No children (0.00%) were previously treated in residential placements twice before their admission to this residential facility. Last, no

children (0.00%) were previously treated in residential placements three times before their admission to this residential facility.

Next, the participants were asked to describe their child's history of psychiatric hospital treatment. None of the children (00.0%) had previously been admitted to the psychiatric hospital on one occasion. Reportedly, 66.7% of the children had previously been admitted to the psychiatric hospital twice. Also, none of the children (00.0%) had previously been admitted to the psychiatric hospital three times. Last, 33.3% of the children had previously been admitted to the psychiatric hospital four or more times.

Then, participants were asked to describe their child's history of outpatient counseling attempts. Reportedly, 16.7% of the children receiving treatment never attempted counseling in an outpatient setting before their admission to this residential treatment center. Reportedly, 50.0% of the children receiving treatment attempted counseling in an outpatient setting one time before their admission to this residential treatment center. None of the children receiving treatment (00.0%) attempted counseling in an outpatient setting two times before their admission to this residential treatment center. Similarly, none of the children receiving treatment (00.0%) attempted counseling in an outpatient setting three times before their admission to this residential treatment center. Last, 33.3% of the children receiving treatment attempted counseling in an outpatient setting four or more times before their admission to this residential treatment center.

Finally, the participants were asked to state the length of time their child had been in this residential treatment program. Reportedly, 33.3% of participants had children in the beginning stages of the program (three weeks into it), 33.3% of participants had

children in the middle stages of the program (1 ½ months into it), and 33.3% of participants had children receiving treatment at the end stages of the program (3 Months).

### **Context**

The focus group interview was held on a Monday night in June from 6:00 to 8:00 pm at the residential center. It was held in a medium sized family therapy room set up with couches, chairs, end tables, lamps, and pictures. There was one large window across one whole wall of the room, and one door to the room. The participants were part of the regularly meeting parent support group that is mandatory for parents who have a child receiving residential treatment at that center. Parents were explained the study and the support group was asked for six volunteers (with an aim of diversity of ethnicity, gender, and amount of time the child has been in the program). Members became more eager to volunteer when they were told there were snacks and refreshments. Six people stood up and walked out of the room with the researcher to the next room down the hall.

It was noted that the focus group interview was held with equal male and female participants, allowing a chance for the mother and father's parental perspectives to be heard equitably. Most of the participants had only two children in the home. The majority of the participants were Caucasian, with one African American and one Multicultural person each participating. The participants had medium to high family incomes. Their children had treatment histories of mostly outpatient treatment and treatment at the psychiatric hospital. Two of the participants were husband and wife. The participant's children receiving residential treatment had a variety of diagnoses in amount and type. The demographics of this group provided for a mixture of circumstances and

experiences, which provided rich data for the study. Next, the profiles for the individual participants will be described.

### **Individual Profiles**

*Participant #1:* (001N). This participant was a Caucasian male, age 47, and was in a stable romantic relationship at the time of the child's residential treatment. The participant's child in residential treatment was a Multicultural male, age 12, with one sibling residing in the home. The child had been given three mental health diagnoses upon admission to the residential treatment program: Oppositional Defiant Disorder, Anxiety, and Mood Disorder/Depression/Bipolar. The child had a treatment history of four or more attempts at outpatient counseling, two previous admissions in the psychiatric hospital, and no previous admissions to a residential facility. This child was at the middle stage of his residential treatment at this facility, and had been in treatment for a month and a half.

*Participant #2:* (002N). This participant was a Caucasian female, age 47, and was in a stable romantic relationship. The family's income level was stated as high at \$70,000 per year. The participant's child in residential treatment was a Multicultural male, age 12, with one sibling residing in the home. The child had three mental health diagnoses upon admission to the residential treatment program: Oppositional Defiant Disorder, Anxiety, and Mood Disorder/Depression/Bipolar. The child had a treatment history of four or more attempts at outpatient counseling, two previous admissions in the psychiatric hospital, and no previous admissions to a residential facility. This child was at the middle stage of his residential treatment at this facility, and had been in treatment for a month and a half.

*Participant #3: (003I).* This participant was a Biracial female, age 29, and in a stable romantic relationship. The household income level was medium at \$35,000 per year. The participant's child in residential treatment was a Biracial male, age 12, with one sibling residing in the home. The child was given one mental health diagnosis upon admission to the residential program: Attention Deficit Hyperactivity Disorder. Before entering residential treatment, the child had been in outpatient counseling on one occasion, and had no previous treatments in the psychiatric hospital. The child had one previous treatment in a residential facility. This child was at the middle stage of his residential treatment at this facility, and had been in treatment for a month and a half.

*Participant #4: (004J).* This participant was a Caucasian male, age 40, who was in a stable romantic relationship at the time of the child's residential treatment. The family income level was not stated by him on the demographic sheet. The participant's child in residential treatment was a Caucasian female, age 12, with one sibling residing in the home with her at the time of treatment. The child was given two mental health diagnoses upon admission to the program: Mood Disorder/Depression/Bipolar and Compulsive Disorder. The child had a treatment history of attempting outpatient counseling on one occasion, and admission to the psychiatric hospital on four or more occasions. The child had one previous treatment in a residential facility. This child was coming to the end of her stay in this residential treatment facility, and was coming to the end of her third month in treatment.

*Participant #5: (005A).* This participant was an African American female, age 31, who was in a strained romantic relationship at the time of the child's residential treatment. The family had a high income level at \$60,000 per year. The participant's child in

residential treatment was an African American female, age 10, with one sibling residing in the home. The child was given two mental health diagnoses upon admission to the program: Attention Deficit Hyperactivity Disorder and Oppositional Defiant Disorder. Before entering residential treatment, the child had been in outpatient counseling on one occasion, and the psychiatric hospital on two occasions. The child had no previous treatment in a residential facility. The child was relatively new to this residential treatment program, and had been in treatment at this facility for two and a half weeks.

*Participant #6: (006A).* This participant was a Caucasian male, age 52, and was not in a romantic relationship at the time of the child's residential treatment. The family income was stated as a low level, \$22,000 per year. The participant's child in residential treatment was a Caucasian male, age 11, with no other siblings residing in the home. The child was given one mental health diagnosis upon admission to the program: Oppositional Defiant Disorder. Before entering this residential treatment program, the child had not been in outpatient counseling. The child had been admitted to the psychiatric hospital on two occasions. Last, the child had no previous treatment in a residential facility. This child was coming to the end of his stay in residential treatment, and was coming to the end of his third month in treatment.

### **Data Collection and Analysis**

The demographic sheets completed by the participants were documents that were reviewed. They provided the data for the descriptions of the participants above. Data was also collected through a focus group interview and the research team members' field notes from that interview. Research team member two conducted an observation during the interview, which provided data for the context and description sections of the study.



The primary researcher kept a reflective journal and utilized it throughout the data collection and analysis process. The focus group interview was audio taped and then transcribed. After the interview was transcribed, participants were asked to review the transcript for accuracy. Open coding was utilized. The primary researcher and research team member one read the transcripts repeatedly to search for initial themes. First they did this alone, and then met to arrive at a consensus about themes. Themes were also discussed with the peer debriefer. A code book was developed and descriptive statements were written for each theme. The themes were organized into groups of related topics initially. Topics included commitment, improvement, friends, hopelessness/ fear, family relationships/sibling relationships, changes in behaviors, friendships, parenting classes/support groups. Themes were further examined and then reduced to three general topics. General themes included: Help for the Family, Parental Involvement, and Help for the Children. Subthemes included: Parent-Child Relationships, Sibling Relationships, Hope for the Future, Parent Support Group, Parenting Classes, Relief from Fear, Improvements in Interpersonal Relations, Peer Relationships, and Threat of Larger Consequences.

In order to develop categories, the researchers compared the themes and searched for similarities and differences among them. The data was further analyzed to clarify the concepts and for saturation. The topics were also divided into subcategories. The results section contains a presentation of the details of the three categories and their related concepts. The researcher considered the participant's ranges of responses within each category. Specific quotes were identified in order to allow the words of the participants to be used for description of the phenomenon. Rival explanations were sought by the

researcher through review of the literature and conversations with the peer debriefer. Categories were decided to remain as they were. The auditor reviewed the audit trail at this portion of the study.

## Results

The results of the data collection and analysis are presented in this section. In general, all participants of the focus group described the essence of the experience of having a child in residential treatment as a positive one, and the parents associated it with positive improvement for their family and the parent-child relationships. They overwhelmingly reported it as a helpful experience for themselves, their child, and their families as a whole. Parents reported they felt the residential treatment experience was full of good programs (including family counseling, parent-child interactions, and the parent support group) with good staff members. Data analysis resulted in the emergence of three main themes: *Help for the Family*, *Parental Involvement*, and *Help for the Child*. To describe each theme, subthemes are presented that emerged from the transcribed interviews. Quotes from the interview are provided in order to immerse the reader in the experience and to further display the results.

Three main themes from the experience parents had when having a child in residential treatment emerged: *Help for the Family*, *Parental Involvement*, and *Help for the Child*. The theme of *Help for the Family* contained three subthemes: *Parent-Child Relationships*, *Sibling Relationships*, and *Hope for the Future*. Also, the theme of *Parental Involvement* contained three subthemes: *Parent Support Group*, *Parenting Classes*, and *Relief from Fear*. Lastly, the theme of *Help for the Child* contained three

subthemes: *Improvements in Interpersonal Relations, Peer Relationships, and Threat of Larger Consequences.*

### **Help for the Family**

A major theme that emerged from the data is *Help for the Family*. The theme of *Help for the Family* contained three subthemes: *Parent-Child Relationships, Sibling Relationships, and Hope for the Future*. Below the themes and subthemes that emerged are illustrated using verbatim quotes from the interviews.

Residential treatment is used for children and families in crisis. Thus, the families are in a great need of help. The definition of *help* is to ease, aid, relieve, or improve (Houghton Mifflin Company, 2003). Because residential treatment is an intensive service, that help is offered to families in many forms. The parents in this study widely acknowledged that this experience was helpful to their family. The parents discussed their feelings that having a child residential treatment helped their family to make positive improvements in the parents' relationship with their child, and with that child's sibling (if applicable). The parents also reported feeling the experience of having a child in residential treatment was helpful for the siblings' relationships with each other (if applicable). Last, parents in this study also noted as a result of the experience, they had positive hope for the future of their families. One participant stated, "I am very hopeful about it. It's going to be more stable. It can be constant attention there to help him and stuff."

**Parent-child relationships.** A *relationship* is defined as a particular type of connection existing between two people (Houghton Mifflin Company, 2003). The connection between the parents and the children in this study were examined closely. All

of the parents in this study agreed that the residential treatment experience was helpful for their relationship with their child. For example, parents noted their children had become “much more loving” towards them. One father stated his amazement about the increased affection he was receiving from his child since he had been in treatment.

[Child’s name] didn’t want to be touched. Now, he puts his arm around me, and around my shoulder. He’s more loving towards me. Where as before I couldn’t even touch his hand... I just got my hair cut, just a few weeks ago and he’s rubbing the top of my head. He is great. He goes “cool dad”. He is getting more physical towards me.

Another parent talked about his child now being able to express his feelings to his parents.

Like before he would box it all in. The only way I could get him to talk was if I made him mad; angry to the point where he would just spit it all out. Then he would be ok for a little while. He just needed to vent. Now it’s like he slowly talks. I think that’s a huge improvement.

**Sibling relationships.** The parents in this study who had children in the residential program with siblings living in the home all noted improvement in the child’s relationships with those siblings since treatment had been initiated. This study revealed relationships were not only improved for the child in treatment and his or her sibling, but were also improved for the parents and the sibling. For example, parents stated they were relieved to find out they had more time to give attention to the siblings and “work on that relationship” while the other child was in residential treatment. Several parents in the

study explained the child in treatment had been focused on for a long time, and now that they were out of the house, they were seeing the sibling's problems. One parent noticed:

Now, that [child's name] is here, it gives me a chance to see her for who she is too. Because [child's name] was always in so much trouble that no matter what she did, it was always him. It was never her fault. He was always the one punished; always the one yelled at. But now that he is gone, I was like hold up, you got away with a lot of stuff. So now I can adjust her a little bit, while he's here getting the adjustment he needs, which helps us as a whole.

The parents in this study discussed the child in treatment's severe behaviors and violence that caused their younger siblings to be afraid of them before they entered treatment. Several parents commented that the fear has dissipated since the child has been in treatment. Parents in this study talked about how the children had been violent toward younger siblings or even threatened to kill them. One parent stated:

My daughter is not problematic in school, but when she came home, she let all the anxiety out, took it out of on all of us. So I think... and her brother, she threatened to kill him and stuff like that. He got to sleep in our room every night. He was afraid to sleep in his room because he was afraid that she would come down there to hurt him.

This comment above also further indicates the parents sense being relieved from fear when their children were placed in treatment.

The majority of the parents in this study also expressed relief to discover that the children can get along with their siblings now that they previously could not get along with. One participant commented:

But, yeah, I love it! I'm happy, she's happy, my son's happy! We get together and it is just so loving. And they're playing the Wii, and it's just quiet while mommy rests and I just love it.

**Hope for the future.** When the family began receiving help and started noticing improvements in the parent-child relationships as well as the siblings' relationships, they began to have hope. This study revealed parents displayed a significant amount of hope that things would continue to get better for their families in the future. All of the parents in this study felt that their children "appreciated being home now," after being in residential treatment and being on "such a strict, structured schedule." Additionally, several parents in this study reported they were hopeful for continued improvements in their children. The parents in this study discussed that they had "learned skills from the program" and "families bonded" and that these things helped them be "hopeful for continued change." Several parents in this study reported the parent child interactions were helpful because they got time to have fun time together as a family. One parent stated:

It gave me and my son a chance. I bring my daughter too. It gives us a chance to do something as a family... It was one of the better experiences. We really enjoyed ourselves. We did something that we don't get a lot of time to do at home because when we are at home the first thing the kids say is "can we go outside?" Not, "Hey mom can we play a game?" The only time they want to play a game or watch TV is when it's time for bed. So I have really enjoyed the parent and kids activities.

In another example, two parents reported the mothers in their families were quitting their jobs when the child was discharged from treatment in order to be available to give their troubled children more attention in the future.

### **Parental Involvement**

A second major theme that emerged from the data is *Parental Involvement*. The theme of *Parental Involvement* contained three subthemes: *Parent Support Group*, *Parenting Classes*, and *Relief*. The themes and subthemes that emerged from the interviews are illustrated using verbatim quotes.

In addition to helping the emotional or behavioral disordered children through placing them in a residential treatment facility, parents often needed assistance too. Residential treatment is often used as a treatment of last resort. The parents in this study discussed that they had been through a lot by the time they got to the point of placing their child in residential treatment, and often they were in need of help for themselves. The parents with children in this residential center were provided with several forms of support. Also, the residential treatment center set up programs intended to educate the parents about parenting skills. The parents in this study discussed their perceptions of that education. Last, the parents in this study revealed they found relief when their children finally were placed in residential treatment.

**Parent support group.** A *support group* is a group of people who provide each other with moral support, information, and advice on problems relating to some shared characteristic or experience (Houghton Mifflin Company, 2003). In the case of this study, the shared experience was being a parent with a child in residential treatment. This study also revealed all of the parents interviewed felt the weekly Parent Support

Group “was the most helpful part of the program” for them. Parents in this study discussed how they “enjoyed the connection” that they found with others. They described how they enjoyed meeting and “being able to support and help other members” of the group. This study revealed the normalization aspect of the group was also beneficial because parents enjoyed “not feeling alone” and “seeing that there were other families experiencing the same problems” that they were experiencing. The majority of parents in this study reported feeling they “were the only ones” going through these problems before they come to the support group. They primarily felt they benefited and “enjoyed the support” they received from the other members and staff at the support group. One parent reported it was important for him to hear that, “You are entitled to a break, you are a worthy person, and you do not stink at all this.” Another parent commented, “Really good support to the parents. Love it! Everybody needs support, you know. I mean, you can take that.”

**Parenting classes.** In addition to attending a parent support group, the parents in this treatment program were also required to participate in classes in which they learned parenting skills. According to systems theory, it is not helpful to provide treatment to a child and then place them back into the same family system from which they came without providing intervention to the entire family system. Accordingly, many residential treatment programs require parents to take parenting classes as a form of psychoeducation. However, the parents in this study had a heated discussion that revealed they all “did not feel the parenting classes were helpful.” Some parents discussed their perception that “the information was too theoretical”. One parent stated, “You have to search through the needle in the haystack for the material that you can use.”



Also, some parents reported their view that “only actual parents should be the only teachers of the class.” Parents described their perceptions that parenting classes should contain “hands on activities and practice role –plays”. Also, the majority of parents in this study discussed their view that parenting classes at residential treatment centers need to discuss how to parent “children with specific diagnoses.” The majority of parents in this study stated the only reason they continued until the end of the classes was so their child did not “suffer consequences.” One participant stated, “I mean, it wasted 15 hours of my time.”

**Relief.** In contrast, the parents also reported feeling relief. *Relief* is defined as a pleasant change, or the easing of a burden or distress such as pain or anxiety (Houghton Mifflin Company, 2003). Most of the parents experienced a feeling of relief once their child was in residential treatment. These parents discussed that there were several struggles associated with having a child in need of residential mental health treatment. All of the parents reported they were “at the end of their rope” with their child before coming for treatment. Several parents in this study primarily reported they “didn’t know what else to do” about their child’s problematic behaviors before entering treatment. This study confirmed children were exhibiting violence toward parents, teachers, peers, and siblings before entering residential treatment. Parents talked about police intervention often being required; they were called to the home or brought the children home.

The parents in this study felt their children displayed a lack of respect for authority, including parents, teachers, and the police, before entering residential treatment. One participant stated, “She was against me, her dad, her brother, police,

teachers... anybody.” Some parents stated they were even afraid of their children before they entered treatment. One participant commented, “It was getting to the point where she was either going to kill us or something had to be done.”

Thus, this study revealed most of the parents were exhausted when their children finally entered treatment. For example, one parent reported she “could finally sleep the first night” her child was in residential treatment. The majority of the parents in this study also reported they felt safe with their children at the residential center. The parents discussed their perspective that the staff informed them about their child as needed, and were “very professional and ethical”. One participant stated:

I don’t have to worry at night. I’m not worrying about the kids. I don’t have to worry about the staff. I also know that I can call. I don’t care what staff member... I just want to check on my son. I even came up here a few times. You can’t see him. I’m like, Look, at least tell me if he’s ok. But, they do work with you. And they understand. I think the staff here is awesome.

### **Help for the Child**

An additional theme that emerged from the data was *Help for the Child*. The theme of *Help for the Child* contained three subthemes: *Improvements in Interpersonal Relations*, *Peer Relationships*, and *Threat of Larger Consequences*. These three subthemes are described below, containing quotes from the participants.

For the purposes of this study, the *child* refers to the client receiving the mental health treatment, and is between the ages of ten and twelve years old. The main goal of residential treatment is to treat, or help the child. This section will discuss the parents’ perceptions of how the residential mental health treatment was or was not helpful for

their child. All participants in this study felt the residential treatment experience was overall a “very helpful” one for their child, even if the child “did not want to be there.” Parents discussed they noticed that since their child had been in the residential treatment program, they had seen improvements in the child’s “interactions with other people in general.” Parents discussed their views that their children were better able to make friends since entering residential treatment. Last, parents discussed their realization that things other than residential treatment had been helping their child to make improvements, including the “threat” of being placed in a more intensive treatment facility.

**Improvement in interpersonal relationships.** The first subtheme of this theme involves the children in treatment and their relationships with those around them. Many children entering residential treatment are unable to get along with others. They have problems relating to peers, family members, authority figures, and even people they come into brief contact with in the community. The parents in this study primarily felt they noticed an improvement in their child’s relationships with others. Also, parents felt their children had learned responsibility at the residential treatment center. Additionally, most parents discussed their feeling that their children were now demonstrating respect to authority. Several parents in this study commented that their child was more compliant with rules when someone gave him or her a direction, when previously they would have been rude. Also, most parents noted that their child is no longer violent towards others in situations where they previously would have been.

Last, all parents agreed that although their child had made major improvements, they still needed work. One participant commented, “I mean, she does it, she's not perfect. She'll slip from time to time. We will still have real bad weeks.”

**Peer relationships.** When discussing how children relate to people, one must discuss their peer relationships. Peer relationships are a significant part of a child's life. Many children with emotional or behavior disorders are not able to maintain many friendships due to their behaviors and lack of social skills. The parents in this study discussed how their children had problems getting along with friends and keeping friends at their previous schools and in their neighborhoods. One parent commented:

My son made the comment that all the kids here are just alike but, eventually he would have to leave here. I get scared when I think of him going back to regular school. He would revert back to where he was. And he would be like, “If I act up some more, I can go back.” I defiantly don't want that to happen.

This study revealed the parents perceived their child to be making more friends in residential treatment because their child “was able to fit in” with the others. The parents perceived this to be because in residential treatment they “were with other children that had problems” like their own. One participant reported:

My daughter went to school with other children that treated her differently. They say she was different and here they treat her the same because all of them kids have the same problems. So they can help each other.

Additionally, parents in this study discussed the social skills the children were learning in the residential treatment program. The parents in this study talked about the children “learning from their peers” and “modeling appropriate social skills” for others.

For example, parents discussed how children that had been in the program longer than others “would take the new children under their wing”. In the interview, parents were surprised to learn from other parents in the group that children (including their own) would help other children when they “needed to calm down” or have someone to talk to.

He’s picking up great habits from certain kids. They are learning to work together. When somebody says “Was it you?” All the kids will be like, “You might as well talk, give in, do what you got to do”. My son learns a lot of things like love. It’s awesome! Sometimes, he said “I was going to act up, but then,” he says, “I got to calm down and didn’t get upset.”

**Threat of larger consequences.** The last subtheme involves the children realizing there are very serious consequences for wrongdoings. Many children in residential treatment display serious acting out behaviors before entering treatment, including violence. This study confirmed the same was the case for these children and these parents. The majority of the parents in this study discussed that because of the seriousness of the behaviors, the children received consequences for those behaviors and many of the children viewed the residential treatment as a punishment for their acting out behaviors. Several parents’ comments included the perception that in addition to the residential treatment, their child was also motivated to make positive changes because they were afraid they would have more severe consequences for their misbehaviors than residential treatment.

I said, “You mess up one time. Is that what you want?” The consequence of screwing up further, they should be present. They need to know that if you screw up so badly, then someone else will take care of you. Then they take over it over.

I mean I'm just not going to have any other options. I think that is important for them to know. Because it is certainly important for my son to know.

In addition, one parent reported she worked at a more intensive boot camp like treatment facility and she often took her son there. He was aware this could be a next step if his behaviors got out of control again. Another parent noted the child had a family member in jail, and the child was made aware that is a possible placement if their violence continued to escalate. In summary, the parents felt the children understood the seriousness of other facilities now that they had been in residential treatment.

The observers noted the parent participants appeared uncomfortable during the focus group interview when asked about their specific parent-child relationships. The group participants appeared to be more comfortable discussing matters related to the entire family, or to their child, rather than discussing themselves and their own behaviors.

### Summary

In summary, this qualitative portion of the research study revealed the overall experience of having a child in residential treatment was a positive one, with multiple benefits for the parents, child, and family as a whole. The exception to this was the parent's dissatisfaction with the parenting classes. Specifically, the study revealed the parent-child relationship can be associated with many positive benefits of the residential treatment experience. Three major themes emerged from the data. The themes were: *Help for the Family*, *Parental Involvement*, and *Help for the Child*. Further, each theme was broken down into three subthemes. The theme *Help for the Family* contained the subthemes *Parent-Child Relationships*, *Sibling Relationships*, and *Hope for the Future*. The theme *Parental Involvement* contained the subthemes *Parent Support Group*,

*Parenting Classes*, and *Relief*. Last, the theme *Help for the Child* contained the subthemes *Improvements in Interpersonal Relations*, *Peer Relationships*, and *Threat of Larger Consequences*. Each theme and subtheme was described in detail. Examples were provided and quotes from the focus group participants were included from the transcribed interviews.

### **Integrating Quantitative and Qualitative Findings**

This study examined the parental perspective of the associations between children's residential mental health treatment and the parent-child relationship. Participants of the entire study were the parents of children receiving residential treatment in an Eastern United States residential facility. Archival data was utilized for the quantitative portion of the study and it was supplemented by a qualitative portion of the study that included a focus group interview. The PCRI and IPA instruments were used to measure the parental perspective of the parent-child relationship pre and post residential treatment of the child. Results from the *t*-tests utilized to compare pre and post treatment means indicated there were significant changes on all scales. On average, the participants in this study indicated they had the perceptions that after their child participated in residential treatment, they had less discord in the parent-child relationship, they were more supported in parenting, they were more satisfied with parenting, they communicated more with their child, they were more involved with their child, and they set more limits as a parent than they did before their child entered residential treatment. Next, a focus group interview was conducted to obtain in depth information about the phenomenon of parents having a child in residential treatment and its associations with the parent-child relationship. Results from the qualitative portion showed the essence of

having a child in residential treatment was overall a positive one and a beneficial one. Results also indicated it was associated with improvements in the parent-child relationship. The three major themes and their subthemes that emerged from the data were the first theme *Help for the Family* with subthemes *Parent-Child Relationships*, *Sibling Relationships*, and *Hope for the Future*, the second theme of *Parental Involvement* with subthemes *Parent Support Group*, *Parenting Classes*, and *Relief*, and the last theme *Help for the Child* with subthemes *Improvements in Interpersonal Relations*, *Peer Relationships*, and *Threat of Larger Consequences*.



## CHAPTER FIVE

### DISCUSSION

A concurrent explanatory design (Hanson et al., 2005) was used to examine parental perceptions of the association between children's residential mental health treatment and the parent-child relationship and to examine the lived experience of parents that had a child receiving residential mental health treatment. Archival data were utilized, specifically the Index of Parental Attitudes, the Parent-Child Relationship Inventory, and a demographics sheet was developed from analyzing the relevant literature. They had been completed by parents of children receiving residential treatment before the children entered treatment and after they had completed residential treatment. Paired sample *t*-tests were performed on the data to compare the means of the tests taken by the parents' pre and post treatment. To elaborate further on the topic, a focus group interview was also held with parents who had children receiving residential treatment.

The results of this study include several potentially important findings. The results of the hypothesis testing through paired samples *t*-tests indicated there was a significant change in all scales tested. After participating in residential treatment, parents perceived that they were experiencing greater support, satisfaction with parenting, and parental involvement, and were communicating with their children more often and in more positive ways after they had been in residential treatment, as compared to before they participated in treatment. Results from the quantitative portion of the study indicate parents have the perception that residential treatment may be an effective means of assisting them to communicate in more appropriate ways with their child, and to set more

appropriate limits with their child. Results also indicated parents perceived their child's residential treatment to have provided them with support as a parent and to have enabled them to become more satisfied as a parent, thus, potentially enabling them to parent more effectively and/or improving the parent/child relationship. Results indicated parents perceived they became more involved with their children and aware of their children's needs, after their child's residential treatment, potentially enabling them to improve their parent-child relationship. Finally, quantitative results indicated parents perceived there to be less discord in the parent-child relationship after the child completed residential treatment, as compared to before the child entered treatment, indicating less potential for abuse and conflict in the parent-child relationship. These findings should be interpreted while considering the small effect sizes found in all but one of the areas examined.

The results of examination of the lived experience of parents that had a child receiving residential mental health treatment revealed parents perceived the experience to be a positive one. Responses from participants indicated that the parents felt their families were greatly helped by the residential treatment of their children, including themselves, the children, the parent-child relationships, and the sibling relationships. The parents reported finding hope and relief from their children participating in treatment. The parents indicated an overall positive perception about the residential treatment and its associations with their family, in general.

These findings indicate children's residential mental health treatment can be associated with parental perceptions of significantly positive changes in the parent-child relationship. This research helps to make the case for utilizing residential treatment as an option for children when families are in crisis. These results indicate that it would be

useful for residential treatment centers to be sure to have a support group offered for parents. They indicate residential treatment centers may want to revisit the usefulness of material presented in parenting classes, or ways in which it is presented. Although parents indicated the usefulness of the possibility of further consequences as a motivating factor for children in residential treatment, current literature supporting this idea was unavailable.

The results of this study indicate this group of participants found the residential treatment of their children to be a helpful experience for their families. The results of the focus group interview further indicated the parents perceived that the experience of having a child in residential treatment was associated with positive changes in their family, including the sibling and parent-child relationships.

It is notable that the parents agreed on almost everything discussed in the focus group. Participants were encouraged by the facilitators at the beginning of the group to provide negative, as well as positive responses, and reminded that they did not have to come to a consensus on an answer. Facilitators explained that they wanted to hear different opinions about the topics. Yet, still the group was almost always in agreement.

The group had mostly positive things to say about their experience with residential treatment and with its helpfulness to their family. Part of this may be due to the fact that two of the parents had children who were toward the end of their treatment, so they had been through the hardest times already. Also, one of the parents had just put her daughter into treatment and may have been experiencing a honeymoon phase of first getting to see some great changes quickly. However, half of the parents had children

who were in the middle of their treatment, and they also had mostly positive comments about residential treatment and their family's experiences with it.

Also, the parents seemed uncomfortable at times when asked about their specific parent-child relationships. When facilitators would redirect the discussion back to that specific topic after participants had veered far from the original question, participants would focus on their child, or on their child's behaviors, instead. It seemed as if they were more comfortable sharing information in a group setting about their child, rather than themselves.

### **Comparison to Previous Research**

Previous research states that residential treatment is often used as a treatment of last resort (Frensch & Cameron, 2004; Trout, Hagaman, Chmelka, Gehringer, Epstein, & Reid, 2008). In comparison, this research confirmed that through the focus group interview. Parents expressed that they were exhausted, and even afraid of their children. Many families reported violence and frequent contact with the police. Participants reported they felt they had tried everything else and did not know what else to do when they finally came to admit their child for residential treatment. Also, participants of the qualitative and quantitative portions of the study reported many of the children in residential treatment had been admitted to the psychiatric hospitals before entering residential treatment.

In the literature, the majority of authors have reached a consensus that there has been a general lack of progress in the evaluation of residential services (Chamberlain, 1999; Curry, 1991; Lyman & Campbell, 1996; Whittaker & Pecora, 1984). According to Quay (1986), Studies that examine differential treatment for children and youth are

lacking in the literature. Also, studies that evaluate residential treatment through matching the type of residential treatment with children's characteristics are rare (Chamberlain, 1999; Wells, 1991). Last, children's developmental characteristics and assets are often ignored in research studies involving residential treatment. In comparison, in this research study, it was also not possible to evaluate those complexities of the residential treatment.

Brown and Greenbaum (1994) found that any gains made during a stay in residential treatment disappear quickly after children are discharged, and children continue to return to residential treatment centers. They state they are partially ineffective because of lack of family involvement (Brown & Greenbaum, 1994). In comparison, this research examined parental involvement in order identify potential ways to involving families in treatment at residential centers. Through the focus group interview, results indicated providing parents with support, particularly through parent support groups is a beneficial way to get families involved, while mandatory parenting classes, may not be as effective.

In a review of available studies, Frensch and Cameron, 2004 noted in multiple studies with other researchers evaluating residential treatment, components need to be clearly defined and operationalized, it needs to be clarified when residential treatment is warranted, and there is limited application of findings. In comparison, these statements could be said about this study; however examining the topic of the parent-child relationship within the residential treatment did not allow for such complex examination of the treatment program. Conclusions about the effectiveness of residential treatment itself, through this study and the other literature need to be made cautiously.

Some researchers (Burns et al., 1999; Farmer et al., 2004; Lyons, 2004) claim the effectiveness of residential treatment has not been clearly specified. While not clearly specifying residential treatment effectiveness, this study was able to indicate very specific results regarding the parent-child relationship as it is related to residential treatment. The results of this research indicated that parents had the perception that their children's residential treatment was helpful for their children, for their families, and for the parents. The results of this research also indicated that parents had the perception that their parent-child relationship was associated with improved functioning in the areas of parental support, satisfaction with parenting, parental involvement, communication, limit setting, and level of discord.

Many studies examining residential treatment have a research design consisting of reporting some measure after treatment has ended or using only pre- and post measures of functioning (Frensch and Cameron, 2004). Johnson, Kent, and Leather (2005) cite a problem with most studies done in the area of parent-child relationships as being cross-sectional and only correlational, leading to problems of interpretation. In contrast, this study had a more complex research design through adding a qualitative component onto the quantitative piece, making it a mixed methods design.

### **Limitations of the Study**

These results should be considered within the strengths and limitations of this study. A strength of this study was the concurrent explanatory design format. Utilizing a quantitative method and a qualitative method allowed for exploration of this topic in greater depth, while allowing for results to be somewhat generalizable.

First, the study was limited because the data was gathered from only one residential facility, which limits the generalizability of the findings to other residential populations. Researchers may have been able to take these quantitative results and generalize them to be true for other residential facilities if the participants had been gathered from several residential facilities in several geographic areas, rather than just the one. However, the researcher only had access to the one residential facility at the time of the study. The findings of the qualitative piece of the study were not intended to be generalizable, but rather were for exploration of the phenomenon. However, the fact that the participants for the focus group interview were mainly Caucasian and from middle to high income families can serve to make this data less generalizable.

Also, the evolution of the program could be considered a limitation of the study. The quantitative information was gathered in a time period of more than a year. Then, the qualitative data was not gathered until six months later. Changes in the program had surely taken place in those six months. The researcher also had little control over treatment fidelity. Another limitation was the use of an outside transcriptionist.

This study was limited in that information was gathered on the parental perspective only, and the child's perspective was not examined. Examining the parent-child relationships and its associations with the child's residential mental health treatment from the child's perspective, also would have made the research study more complete. This particular residential program chose not to gather information from the child's perspective due to the difficulties of getting cooperation from children with behavioral disorders and getting subjects to cooperate at the time of admission to residential treatment.

The format of the self-report questionnaire was an additional limitation of the study. The researcher only gained information through what the parent was willing to report in the questionnaire. Also conducting observations of parent-child interactions would have provided a more complete picture of the parent-child relationship and its relationship to the child's residential mental health treatment. Interviewing the families' mental health clinician would have also provided a more complete and accurate assessment of the parent-child relationship and the child's residential mental health treatment.

Limitations were also present with the instruments used in the study. Although multiple studies have proven this instrument to have adequate psychometric properties, the PCRI was normalized on predominantly white parents. Finally, although this instrument also has been shown to have adequate psychometric properties, the IPA is targeted for use by those who have lived in western culture. The research conducted to validate it relied predominantly on those who have lived in the United States for a very long time. Therefore, it may not be suitable for use with individuals from different cultures. The PCRI's normalization on mostly white participants and the IPA's questionable validity of usage for non Westerners limits the general applicability of these research findings.

In addition, there were the limitations involved with using a focus group interview in research, including: (a) participants possibly being unwilling to disclose certain things in an effort to maintain appearances, (b) each participant having less time to respond (c) having a limited number of questions that could be asked, (d) a need for the interviewers to have group facilitations skills (Krueger, & Casey, 2008) (e) the fact



that confidentiality cannot be ensured to the group participants (Krueger, & Casey, 2008) (f) it takes place outside natural social interaction settings (Patton, 2002) and, (g) major themes can be identified, but not subtle differences (Patton, 2002). Social desirability is also a limitation of this study. The focus group participants expressed mainly positive beliefs about residential treatment, and they typically came to a consensus when discussing each topic; possibly indicating that their answers to interview questions may have been impacted by a desire to be socially acceptable.

Also, potential researcher bias is a limitation of this study. This is a limitation of all qualitative research studies. This research bias could have come from anyone in the research team, including the primary researcher. This was addressed through the use of identifying and discussing those biases and how they may affect the research study, the researcher remaining aware of those biases, and utilizing a research team. The researchers also attempted to compensate for this by using bracketing as the first part of data analysis. Also, a peer debriefer and an auditor were utilized to help eliminate some of the researcher bias that could be present in the study. The dissertation committee was utilized for discussion throughout the study. Finally, the primary researcher kept a reflective journal throughout the experience.

A final limitation of this study is that the research is based on perceptions rather than reality. Reality is defined as “That which exists objectively and in fact.” (Houghton Mifflin Company, 2003). To perceive means to become aware of directly through any of the senses,” or “to achieve understanding of.” (Houghton Mifflin Company, 2003). The research data was perception based data. Therefore, what was measured was a perception of change, not an actual change in the parent-child relationship.

### **Challenges within the Research Process**

As with any research study, there were problems that arose during the data selection and collection process. First, the pool of people from which to gather participants was smaller than expected. The parent support group from which the researcher gathered volunteered had been averaging 19 participants for the last six months. On the evening of the focus group, only 11 people were present. This gave the researcher less control over choosing a diversity of research participants.

Second, participants in the focus group seemed unwilling to discuss contrasting views. They had a consensus on almost every topic, or if they did not agree to what the majority of the participants were saying, they did not say it.

Last, participants in the focus group seemed uncomfortable discussing specifics of the parent-child relationships. They preferred to discuss only their child's part in the relationship, or their child's behaviors. Participants would go off topic when facilitators asked about the actual parent child relationship.

### **Implications for Counselors**

The research findings have important implications for counselors. The study raises questions to counselors about how the mental health treatments that they provide to children are associated with the parent-child relationship. A finding of this study for counselors was the need to provide support to parents. The research findings are also significant for counselors in that counselors can now be aware of the potential effectiveness of residential treatment on parenting variables. In addition, since this study provides evidence for the usefulness of residential treatment, and the literature points to a reduction in recent funding; this implies there is a need for counselors and counselor

related associations to lobby for further funding for residential treatment and for the importance of residential treatment in the continuum of care for children's mental health treatment.

These results also have the potential to impact future children receiving residential treatment. These results have pointed to benefits of residential treatment, specific areas that are benefited by the residential treatment, as well as aspects of treatment that parents find helpful. Now, counselors can use this information to use what is effective when working in residential treatment.

### **Implications for Counselor Educators**

This study and its corresponding findings have significant implications for counselor educators. Again, the study raises awareness to counselor educators about the importance of the parent-child relationship and its associations to children's mental health treatment. It also raises awareness to counselor educators about the importance of residential treatment for children and its place in the continuum of care. It is hoped that the raised awareness on these issues encourages counselor educators to open discussions in their classrooms with future counselors and therefore raise their awareness, also. The study gives counselor educators the foundation they may need to conduct research of their own in the area of residential treatment of children, children's mental health, or parent-child relationships.

### **Implications for Future Research**

Children's mental health, the parent-child relationship, and residential treatment are all areas that need more research literature to be fully understood. The findings from

this research study imply that residential mental health treatment can be helpful for families and imply parents do perceive their parent-child relationship as changing in the positive direction after treatment. The finding that parent support groups were a very helpful part of the treatment program for the parents is an interesting finding that emerged from this study and could be considered for future research. Further research on the value of parent support groups or a more in depth study of parent support groups for those with children in residential treatment would be beneficial. Another interesting finding that emerged from the study was the parents starting to notice the siblings' problems in the home once the other child left for residential treatment. This also could be considered for future research. Research on how one child in the family going into residential treatment impact siblings would also be useful.

The limitations of this research study point to directions for future research. To further explore the association between the child's residential mental health treatment and the parent-child relationship, a mixed methods study designed to include parent-child interaction observations, and interviews with the families' mental health clinicians, in addition to the self-report questionnaires could be conducted. This would enable a more complete picture of the parent-child relationship to be gathered. This work leaves open the opportunity for future research and a continued refinement of residential mental health treatment for children and its associations with the parent-child relationship.

Further research needs to be conducted in this area to further determine the relationship of residential treatment and the parent-child relationship. There are many avenues for future research that stem from this research study. A quantitative study that would further our understanding of the parent-child relationship and its relationship to

residential mental health treatment would be to replicate this study from the child's perspective. Future research can build upon this research and utilize instruments designed for use by children to examine their perceptions of the parent-child relationship. Ideally, a study would examine the relationship from both the parent and the child perspective. Examining the relationship from the perspective of all parties involved would make the research study more complete.

Another quantitative study that would further our understanding of children's residential mental health treatment would be a study focused on multiple residential facilities. For example, a future researcher may choose to gather data similar to data gathered in this study, from three local area residential facilities for children. Including multiple residential facilities would increase generalizability. Researchers could compare the results at the different residential centers and determine if they were getting similar results at each residential center, thus meaning the results were generalizable.

It would also be beneficial for researchers to examine the improvements of children and the parent-child relationship longitudinally, post treatment. It would be useful for researchers to further examine varying types of follow up treatments and post treatment programming. This would provide information related to whether or not the benefits of the residential treatment implied by this research are lasting.

### **Conclusion**

The purpose of this study was to examine parental perceptions of the associations between children's mental health treatment and the parent-child relationship and to examine the lived experience of parents that had a child receiving residential mental health treatment. The study utilized a non-experimental concurrent explanatory design.

Parental Support, Satisfaction with Parenting, Parental Involvement, Communication, Limit Setting, and Parental Attitudes were specifically explored.

Results of this study through statistical analysis by paired samples *t*-test indicated a statistically significant change on all scales measured. It was found that parents of children in this residential facility have perceptions of greater support, greater satisfaction with parenting, greater involvement with their children, a greater amount of positive communication, do a greater amount of limit setting, and have less discord in the parent-child relationship as compared to before the child participated in residential mental health treatment. Results of the study through examination of the lived experience of parents that had a child receiving residential mental health treatment found that parents with children receiving residential treatment at this facility perceived the treatment to be helpful for their child, themselves, and their family as a whole. They perceived a sense of relief and a sense of hope from their children participating in residential treatment.

This study had a number of limitations that affected its findings, including; perception based data, lack of generalizability due to only using one residential treatment facility in the study, incomplete perspective of the parent-child relationship coming from the parents only, and instrumentation issues, including only using self report questionnaires and using instrument predominately normed on Whites living in the US for a long period of time, making their generalizability questionable. Additional limitations included using an outside transcriptionist, and limitations arising from the use of a focus group. However, the study has important implications for counselors and counselor educators in that it has demonstrated an overall parental perception that residential treatment for children has positive associations with the parent-child

relationship. It has also raised awareness of the importance of children's residential mental health treatment and its associations with the parent-child relationship.

Directions for future research include: replicating the study with a higher number of participants, expanding the study to include the child's perspective of the parent-child relationship, including observations and clinician interviews in addition to self-report measures, examination of data further post-treatment with different aftercare options being evaluated, and increasing the number of residential treatment centers included in the study for increased generalization purposes. In conclusion, this study was a first step at examining the associations between children's mental health treatment at residential facilities and the parent-child relationship. It is hoped that future researchers build upon this foundation and continue to create knowledge in this important area.

## **CHAPTER SIX**

### **RUNNING HEAD: RESIDENTIAL TREATMENT AND PARENT-CHILD RELATIONSHIPS**

**The Association between Parental Perceptions of Children's Residential Mental  
Health Treatment and the Parent Child Relationship**

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### Abstract

The purpose of this mixed-methodological study was to examine the association between perceived changes of the parent-child relationship after children's residential mental health treatment. Paired samples *t*-tests indicated statistically significant changes in parental support, satisfaction with parenting, parental involvement, communication, limit setting, and parental attitudes after children's residential treatment. Further, the lived experiences of parents with a child participating in residential mental health treatment were investigated through a focus group interview. Results indicated parents perceived the treatment was beneficial, through the themes of Parental Involvement, Help for the Families, and Help for the Children.

## The Association between Parental Perceptions of Children's Residential Mental Health Treatment and the Parent Child Relationship

Between 10% and 20% of children (over 7.5 million) have a mental health problem (Rethink, 2009), and a serious mental health condition is present in 1 out of every 10 children in the U.S. (U.S. Public Health Service, 2000). Children are being identified with behavioral problems at an earlier age (Keenan & Wakschlad, 2000), and the number of children with behavioral problems (e.g. aggression, delinquency, withdrawal, social problems, somatic problems, defiance, theft, destruction to property, lying, running away from home, and sexual impulsivity; Morrison & Anders, 1999) has been continuously increasing over the last two decades (Kelleher, McNerny, Gerdner, Childs, & Wasserman, 2000). Further, SAMHSA (1999) detailed that common diagnoses of children that have been diagnosed with a mental illness are: attention deficit hyperactivity disorder (36.5%), mood disorder (31.8%), oppositional defiant disorder (26.6%), adjustment disorder (12.9%), conduct disorder (11.7%), post-traumatic stress disorder (8.6%), substance use (7.6%), V-code (5.7%), disruptive behavior disorder (5.3%), learning and related disorder (5.2%) impulse control disorder (5.2%), anxiety disorder (4.2%), mental retardation (3.7%), psychosis (2.2%) and autism and related disorder (1.9%). The purpose of this mixed-methodological study was to examine the association between perceived changes of the parent-child relationship and the child's residential mental health treatment. Literature on residential treatment programs and treatment outcomes, as well as parent-child relationship components, is presented. For the purpose of this study, the term "parent" refers to a child's mother, father, stepmother,

stepfather, grandmother, grandfather, guardian, or other caregiver residing with the child and acting in the parenting role.

### **Residential Treatment Programs and Treatment Outcomes**

Although the primary treatment model for children with behavioral and emotional disorders is outpatient therapy (Northey, Wells, Silverman, & Bailey, 2003) with approximately 5% to 10% of children and their families utilizing outpatient counseling services (Northey et al., 2003), residential treatment programs may serve children and adolescents who first failed in other treatment programs (Frensch & Cameron, 2004; Trout, Hagaman, Chmelka, Gehringer, Epstein, & Reid, 2008).

The number of children treated in residential facilities and the length of treatment time is increasing and will continue to increase in the future (U.S. Department of Health and Human Services, 1999). Frensch and Cameron (2004) conducted a review of studies of residential treatment effectiveness delivered in group home settings and residential treatment centers and concluded that, despite methodological shortcomings and variability in programming, residential services did improve functioning for some youth. Improved functioning was noted in the areas of improved psychological adjustment, improved school performance, reduction in the mean criminal offense rate, improved peer relationship skills to an adequate level, and improved interaction skills with authority to an adequate level or higher.

Other studies support the effectiveness of residential treatment. Leichtman et al. (2001) studied 123 adolescents with severe psychiatric problems and reported that intensive, short-term residential treatment resulted in a clinically substantial improvement

from admission to discharge, and improvement was sustained for the year following discharge.

There is an association with children who have stronger familial relationships and their treatment outcomes. Residential mental health treatment centers often incorporate family interventions that aim to improve the strength of the parent–child relationship and restore family functioning. Treatment of the child without involvement of the parents and family is unlikely to produce meaningful and long-lasting remediation of problem behaviors and emotions (Walter & Petr, 2008; Nickerson et al., 2007).

Lakin, Brambila, and Sigda (2004) found that children whose parents were more involved in their residential treatment showed lower rates of recidivism and children in families with higher levels of parental involvement in their residential treatment showed better family functioning and less functional impairment. Johnson, Kent, and Leather (2005) stated studies indicate that interventions designed to strengthen the parent-child relationship are efficacious in alleviating behavioral disorders. Further, Frensch and Cameron (2004) found that the level of family involvement in treatment was predictive of post-treatment adjustment.

One assumption behind this empirical support is that parents or guardians are primary agents for children succeeding in treatment (Baumrind, 1995; Collins, Maccoby, Steinberg, Hetherington & Bornstein, 2000; Steinberg, 2001). For this reason, many residential treatment centers are making the transition to more family centered models of treatment (Zielinski & Bradshaw, 2006). A current approach to family counseling in residential centers is to utilize ways of increasing the interaction between families and

emphasizing the family relations as a relevant factor in psychological health (Weingarten, 2010).

Understanding how residential treatment for children's mental health issues is associated with various components of the parent-child relationship may inform understanding of how residential mental health treatment benefits the family, and thus help us create residential programs that help restore family functioning more effectively. Ultimately, this might influence children's mental health, due to the better functioning families.

### **Parent-Child Relationship Components**

There are several parent-child relationship components that will be assessed in this study. These include parental involvement, satisfaction with parenting, communication, limit setting, and parental support.

**Parental involvement.** Parent involvement is a parent's interaction with his or her child and a parent's knowledge of his or her child (Gerard, 2005). Consistently, researchers have discovered that greater parental involvement in a child's education is associated with higher student grades and test scores, better attendance, higher rates of homework completion, higher graduation rates, greater enrollment rates in post-secondary education, and most notable for this study- more positive student attitudes and behavior (Green, 2002). When parents are involved, children achieve more regardless of their socioeconomic level, ethnic/racial background, or the parents' educational level (Henderson & Berla, 1994).

**Satisfaction with parenting.** Satisfaction with parenting is the amount of pleasure and the amount of fulfillment an individual derives from being a parent (Gerard,

2005). Satisfaction with parenting is closely related to parenting self-efficacy. A burgeoning area of research on parenting has concentrated on parenting self-efficacy, defined as parents' perceptions of their ability to influence the behavior and development of their children. Previous research (Young, Karraker, & Cottrell, 2006) has shown that parents with higher self-efficacy are themselves more satisfied with parenting.

**Communication.** Virginia Satir defined communication as the giving and receiving of information between two people (Satir, 1987). Thus, according to Smith (1998), effective parenting is built on communication and planned, ongoing communication is the crucial missing link in many families. Gable (2010) reports research suggests that the most favorable parent-child relationships are characterized by a great amount of positive communication and interaction. According to Gable (2010), the researchers believe that when parents stay connected with children through attention and conversation, children may be less likely to misbehave. Children learn about ways of communicating in personal relationships through utilizing patterns of interactions among family members as a model (Yahaya, 2006).

**Limit setting.** Limit setting can reduce the likelihood of confrontations and can deal with high frequency misbehaviors quickly and effectively (Romano, 2005). Gorney (1994) explained the integration of personal limits, as well as an increasing awareness of the limits of others are both established during childhood and adolescence with the help of parents. According to Webster-Stratton and Dahl (1995), when parents display inconsistent limit-setting with their children, it typically results in behavior problems in their children. Dawson and Clark (1998) discussed that without healthy limits children feel wary and insecure. They could become reckless and uncaring about their welfare.

Dawson and Clark (1998) added that setting limits that are too strict can be unhealthy as well. If parents set limits that are too restricting, children will over-adapt and become passive, or demand attention with rebellious behavior. For these reasons, many residential programs incorporate parenting classes with a major focus on teaching parents how to set limits, into the program curriculum (Neale & Rosenheck, 2000). When healthy limits are set for them, children learn gradually to set their own limits, and to value themselves.

**Parental support.** For this study, parental support refers to the emotional and social support that a parent receives (Gerard, 2005). One component of many residential treatment centers is an intervention designed to support the parent while the child receives treatment. By the time children's behaviors problems have evolved to a level in which residential treatment is being initiated, most parents are overwhelmed and in need of support. Stressors such as difficulty accepting and adjusting to their child's disability, financial demands for necessary medical care, limited (or no) accessible information about their child's disability, time management conflicts, and appropriate respite care and other services to relieve their caretaking activities are burdens that parents have to handle (Ainbinder, 1998). More optimal parenting behavior is associated with informal and formal social support (Torquati, 2002).

### **Research Questions**

The study investigated the following: Is there a significant change in the parent-child relationship for children ages 5-13 years old with emotional and behavioral disorders who have received residential treatment? The following research questions were addressed: (1) Is there a significant change in perceptions of the parent-child

relationship, as measured by the Index of Parental Attitudes at post-residential treatment for parents of children ages 5 to 13 with emotional and behavioral disorders?; (2) Is there a significant change in perceptions of the parent-child relationship, as measured by the Parent-Child Relationship Inventory scales, at post-residential treatment for parents of children ages 5 to 13 with behavioral and emotional disorders? and (3) What is the essence of the experience for a parent to have a child in residential mental health treatment, and how do parents perceive it to be experienced within the parent-child relationship?

Research question 2 was broken into parts for further analysis: (a) Is there a significant change in the level of support a parent perceives to be present, as measured by the Parental Support scale of the PCRI completed by the parents of children ages 5-13 with behavioral and emotional disorders at post-residential treatment?; (b) Is there a significant change in the degree of satisfaction with parenting that a parent perceives is present in the parent-child relationship, as measured by the Satisfaction with Parenting scale of the PCRI completed by the parents of children ages 5-13 with behavioral and emotional disorders at post-residential treatment?; (c) Is there a significant change in the amount of parental involvement that a parent perceives is present in their parent-child relationship, as measured by the Parental Involvement scale of the PCRI completed by the parents of children ages 5-13 with behavioral and emotional disorders at post-residential treatment?; (d) Is there a significant change in the communication in a parent child relationship, as measured by the Communication scale of the PCRI completed by the parents of children ages 5-13 with behavioral and emotional disorders at post-residential treatment?; and (e) Is there a significant change in the limit setting by a parent



in a parent-child relationship, as measured by the Limit Setting scale of the PCRI completed by the parents of children ages 5-13 with behavioral and emotional disorders at post-residential treatment?

Hypothesis 1, corresponding with Research Question 1, stated that there will be a significant difference in parental attitudes post-treatment, with lower scores post-treatment indicating more positive parental attitudes toward children. Hypothesis 2, corresponding with Research Question 2a, stated that there will be a significant difference in level of support post-treatment, with significantly higher scores post-treatment indicating the parents feel more supported and engage in more supportive activities. Hypothesis 3 (Research Question 2b) stated that there will be a significant difference in degree of satisfaction with parenting post-treatment with significantly higher scores post-treatment indicating parents feel more satisfied with parenting their child. Hypothesis 4, corresponding with Research Question 2c, stated that there will be a significant difference in parental involvement post-treatment with significantly higher scores post-treatment indicating greater parental knowledge of the child and an increase in the time the parent is spending involved with the child. Hypothesis 5 (Research Question 2d) stated that there will be a significant difference in communication post-treatment with significantly higher scores post-treatment indicating more positive communication from the parent to the child. Finally, Hypothesis 6, corresponding with Research Question 2e, stated that there will be a significant difference in limit setting post-treatment with significantly higher scores post-treatment, which indicate greater limit setting by the parent.

## Method

In this concurrent explanatory design, quantitative and qualitative data are collected and analyzed at the same time, with priority given to the quantitative data (Hanson, Creswell, Plano-Clark, Petska, & Creswell, 2005). The quantitative component of the design involved analyzing changes in specific aspects of the parent-child relationship (communication, limit setting, parental attitudes, involvement, support, and satisfaction) after a child's residential mental health treatment. Archival data were analyzed that had been gathered from a residential facility in the southeastern United States. The residential facility is a small facility that serves children ages 5 to 13 that exhibit emotional and behavioral problems. Children are referred by school officials or mental health providers, and usually stay about three months for treatment. The children have a high degree of involvement with their families while at the center. Parents visited the center for family therapy once a week, attended a parent support group once a week, attended a parent-child interaction activity once a week, and also attended special events on a regular basis. Children called home daily. The center is highly structured and children are on a behavior modification system throughout their treatment.

Parents at this facility completed the Parent-Child Relationship Inventory (Gerard, 2005) and the Index of Parental Attitudes (Hudson, 1993) between August 2008 and January 2010 for clinical purposes. The purpose of the inventories was for clinicians at the facility to assess the parent-child relationship for problems before treatment, and after residential treatment as part of the clinical treatment plans. Parents of children receiving residential treatment services at this facility completed the two self-report measures described below when distributed by the clinicians as part of the intake process before

their child received residential mental health treatment, and as part of the discharge process after the child received residential treatment. The program administrator then gave permission for the data to be used for this research study as archival data. All identifying information was removed from the inventories and the program administrator assigned an anonymous identification code to participants before this researcher used the data.

The qualitative component of the design involved a focus group of parents of children in residential treatment. Using a phenomenological approach a research team was utilized containing the primary researcher and two other members that were counseling/research professionals to examine how parents experience their child's residential treatment and the parent-child relationship.

A purposeful sampling procedure was used to include parents or parent figures who have a child currently receiving residential mental health treatment at the facility under investigation in this study. The same facility had been used for archival data collection for the first part of the study. The primary researcher approached the administrator of the residential facility used for the qualitative portion of the research and obtained permission to conduct the focus group interview utilizing the mandatory weekly parent support group for participants. Next, the primary researcher met with the parent support group facilitator for coordination.

Participants were recruited from the mandatory weekly parent support group that meets at the facility. The only criteria for participation was to be a parent with a child in the residential treatment facility, however the primary researcher was aiming to have a variety of genders and ethnicities represented. The researcher also aimed to have a

diversity of parents with respect to the amount of time their children had been in residential treatment.

The research team attended the support group one evening in June 2010. All parents at the support group that evening had the research study procedures explained to them by the primary researcher and they were asked if they were willing to participate in the study. The primary researcher reviewed the purpose of the study and the possible risks involved. The research team then asked for six volunteers, requesting that they get a mix of genders, ethnicities, and length of time their children had been in the residential treatment program. Parents began to volunteer, individually. This method provided access to a variety of parents, because parents could see who had already volunteered before deciding if they should volunteer.

Those that volunteered and provided their written informed consent were used as participants for this research study. In qualitative inquiry, there are no rules for sample size (Patton, 2002), however the number of parents that volunteered for the focus group that evening was 6, due to low attendance at the parent support group that evening. The focus group interview was held in a therapy room at the residential treatment center under study. Demographic sheets were completed by each parent in the focus group, providing information on themselves and their child in residential treatment.

Participants were explained the study in depth at the time of recruitment. Next, the participants were asked to sign a consent form. They were also provided with a copy of their signed consent form. Participants signed a release of confidentiality and agreement to be digitally recorded and for this information to be used in a research study. The primary researcher discussed confidentiality and the limits of confidentiality in

groups. Participants were identified as numbers or letters only. The audiotapes were destroyed after use and were kept in a locked cabinet behind a locked door at all times while kept for the study. Regarding protection of participants, participants were explained that declining to participate in the study would not result in any negative consequences or restriction of privileges normally enjoyed by their family or children in the residential treatment program.

### **Participants**

**Quantitative component.** Participants ( $n=70$ ) were eligible for this study if they resided with the child and acted in a parental role. Data indicated the children in treatment were 77.1% male and 22.9% female. In regards to the ages of the children in treatment, data indicated 4.3% of children were 5 years old, 11.4% of the children were 6 years old, 12.9% of the children were 7 years old, 18.6% of the children were 8 years old, 11.4% of the children were 9 years old, 8.6% of the children were 10 years old, 14.3% of the children were 11 years old, 12.9% of the children were 12 years old, and 5.7% of the children were 13 years old. With respect to ethnicity, data indicated 57.1% of the children in treatment were Caucasian, 27.1% of the children were African American, 10.0% of the children were Biracial/Multicultural, 2.9% of the children were Hispanic, 1.4% of the children were Asian, and 1.4% of the children were German.

**Qualitative component.** The focus group interview participants' genders were split equally between males, 3 participants (50%) and females, 3 participants (50%). Regarding ethnicity, four of the participants, or 66.7% described themselves as

Caucasian, one of the participants (16.7%) described himself as African American, and one of the participants (16.7%) described himself as Biracial/Multicultural.

The demographic information that represents the children participating in residential treatment, whose parents participated in the focus group interview, is described below. The focus group participants had children in the residential treatment program whose primary gender were male (66.7%). Only 33.3% of the participants' children in treatment were female. The majority of the focus group participants (four people) had children who were twelve years old (66.7%) at the time they received residential treatment, although the center provided treatment for children ages 5-13. The small age range of the children was not expected. One participant (16.7%) had a child in treatment who was ten years old. Also, one participant (16.7%) had a child receiving treatment who was eleven years old. Half (50.0%) of the participants' children in the residential treatment program were Caucasian, indicating 3 participants' children in this study. The remaining treated children of the participants were Biracial/Multicultural (33.3%, representing 2 children) or African American (16.7%, representing 1 child in the study).

### **Instrumentation**

**Parent Child Relationship Inventory.** The Parent-Child Relationship Inventory (Gerard, 2005) was used in this study. It is a self-report instrument that assesses the relationship according to seven scales for closer examination of strengths and weaknesses of the parent-child relationship. Gerard defines the parent-child relationship as including parent-child interactions, as well as the attitudes, dispositions, and behaviors of mothers and fathers. The parents of the children in treatment completed the survey pre and post

treatment. The scale assesses parents' attitudes toward parenting and toward their children, and is designed for clinical and research settings. The parent responds to 78 items on a 4-point Likert scale. The ratings on the scale range from 1 (strongly agree) to 4 (strongly disagree). Most clients complete the form in about 15 minutes (Gerard, 2005). The range of scores in each scale is 0 to 100. A benefit of the PCRI is the norming sample is based on the responses of both mothers and fathers (Gerard, 1994).

The seven scales that make up the PCRI are: Parental Support, Satisfaction with Parenting, Involvement, Communication, Limit Setting, Autonomy, and Role Orientation. The Parental Support scale consists of 9 items that assess the level of emotional and social support a parent receives. An example item from this scale is, "When it comes to raising my children, I feel alone most of the time." The Satisfaction with Parenting scale consists of 10 items measuring the amount of pleasure and fulfillment an individual derives from being a parent. An example item from this scale is, "I get as much satisfaction from having children as other parents do." The Involvement scale contains 14 items measuring the level of a parent's interaction with and knowledge of his or her child. An example item from this scale is, "I spend a great deal of time with my child." The Communication scale consists of 9 items that assess a parent's perception of how effectively he or she communicates with a child. An example item from this scale is, "My child generally tells me when something is bothering him or her." The Limit Setting scale contains 12 items that focus on a parent's experience disciplining a child. An example item from this scale is, "I have trouble disciplining my child." Two scales were not utilized for this study (Autonomy and Role Orientation) due to the Autonomy scale's unacceptable levels of internal consistency found by some researchers

and due to Gerard's warnings to use the Role Orientation scale with caution. The PCRI also includes two validity indicators: the Social Desirability Scale, which indicates whether the client was operating with a defensive or "fake good" response set, and an Inconsistency Indicator, which indicates if the parent may have been responding randomly or inattentively (Gerard, 2005).

Scores are expressed as normalized *t*-scores with a standard deviation of 10 and a mean of 50. Lower scores indicate poor parenting skills and higher scores indicate good parenting skills. A score less than 40 on any PCRI scale suggests problems in that area. A score of less than 30 on any PCRI scale suggests serious problems in that area (Gerard, 2005). There is no final total score used; only subscale scores are used. Research has supported the validity of the PCRI (Coffman, Guerin, & Gottfried, 2006). Further, the PCRI has good overall internal consistency with a median alpha value of .82 (Gerard, 2005). The PCRI also has good test-retest reliability with a mean scale autocorrelation of .81 (Gerard, 2005). The construct validity based on internal consistency and the correlation of each individual item with its scale, is also good (Gerard, 2005). Additionally, predictive validity is evidenced by a study correlating scores on the PCRI with scores on the Personality Inventory for Children, which showed significant correlations between all scales except for one (Gerard, 2005).

**Index of Parental Attitudes.** The parent-child relationship was also measured in this study by the Index of Parental Attitudes (Hudson, 1993), a paper-pencil, self-report assessment tool that measures the degree, severity, or magnitude of personal and social functioning problems in a parent-child relationship as perceived by the parent (Hudson, 1997). It is a family relationship measure that measures the construct of discord with the



child (Hudson, 1997). Practitioners designed the IPA for use by researchers in repeated administrations with the same clients to assess initial problem status, to monitor client progress over time, and to monitor the course of treatment (Hudson, 1997). The IPA has been found to have good content, concurrent, factorial, discriminate, and constructive validity. According to the WALYMAR Assessment Scales manual, the reliability alpha for the IPA is 0.97, the standard error of measurement is 3.64, and the known groups validity is 0.88 (Hudson, 1997). The IPA is part of the WALMYR Assessment Scales, and is an accurate, valid and reliable means to evaluate clients before, during, and after treatment (Hudson, 1997).

The parents completed the IPA with respect to the parent's relationship with a specific child. In completing the IPA, the parents responded to 25 items on a 7-point Likert scale. The ratings on the scale range from 1 (none of the time) to 7 (all of the time). Examples of items from the measure include: "I feel ashamed of my child," and, "I do not understand my child," and, "I get along well with my child." Scores are true ratio values, ranging from 0 to 100, in which higher scores indicate greater problems with the parent-child relationship. A score of 0 indicates the client has no problems in the parent-child relationship and a score of 100 represents the highest possible distress level that the scale is capable of measuring. A low score indicates the relative absence of problems in the parent-child relationship, and higher scores indicate the presence of a more severe problem in the parent-child relationship. A clinical cutting score is 30, meaning scores above 30 are indicative of problematic parent-child relationships and scores below 30 are indicative of a non-problematic parent-child relationship. Scores above the 70 clinical

cutting score indicate a clinician should be alert for signs of violence or child abuse, and those clients are nearly always experiencing severe distress.

**Demographic sheet.** In addition to the above assessments, a demographics sheet was utilized in this study. Residential client records were examined in order to gather demographic data on children and parents. Specifically, intake forms completed by parents prior to residential treatment admission and admission screening forms completed by the treatment clinician were examined for demographic information.

**Focus group interview.** An interview protocol was designed previous to the focus group interview. A total of 8 questions were asked of the participants within a 1.5 hour period. The interview protocol was used as a guide for discussion in the group. The participants were asked a series of open ended questions about their relationship with their child and residential treatment in general. Examples of questions are, “What have you noticed about your relationship with your child since he or she has been in residential treatment?” and, “How has, if at all, residential treatment been helpful to your family? One question was asked to encourage alternate explanations or to let new themes emerge. Follow up questions were asked based on discussions from the answers to the initial interview questions. The research team also made observations that were used as data.

## **Data Analysis**

### **Quantitative Analysis**

Before conducting analysis of the research questions, data screening, recoding and diagnostics was conducted. Data were analyzed using several paired sample t-tests. Specifically, the researcher examined change scores for the six variables (the IPA, and the five subscales of the PCRI: parental support, satisfaction with parenting, parental

involvement, communication, and limit setting). A t-test was used to assess hypothesized mean differences for these subscales (Green & Salkind, 2005). Assumptions for conducting t-tests were tested. Demographic data was also gathered utilizing a demographics sheet and case records examination and presented as descriptive statistics. Specifically, SPSS version 17 (SPSS, 2008) was used to complete all statistical procedures.

### **Qualitative Analysis**

Prior to beginning the study, all research team members were trained in qualitative focus groups. To improve the trustworthiness of this study, research was conducted in an ethical manner; all data was collected following written consent from participants and in compliance with IRB guidelines. The primary researcher's responses to the research process were monitored by keeping a journal throughout the study to further increase subjectivity. The primary researcher and research team member one reviewed transcribed transcripts of the focus group interviews. The researcher in this study utilized a peer debriefer to help identify and maintain subjectivity and to assist to reflect upon her experiences and to understand them. Any biases and pre-judgments of the primary researcher were continuously monitored and reviewed with an independent observer. Triangulation of multiple research team members were used through the utilization of a research team. The researcher analyzed the data to the point of redundancy. Member checking was utilized in that the transcribed interviews were provided to the participants to check for accuracy, and changes were made in response to their feedback. In addition, a detailed audit trail was utilized which included field notes, written communication between research team members, and codebooks showing the

code development process. An auditor provided an ongoing review and evaluation of the study that included trustworthiness of the procedures, the audit trail, and outcome. The primary researcher remained open to multiple perspectives and complexities as they emerged and was balanced in reporting confirmatory and disconfirming evidence with regard to conclusions offered.

## **Findings**

Table 2 indicates descriptive statistics for the IPA and the PCRI. The six parent-child relationship components, each assessed in a research question or sub-question, included the following: parental attitudes, parental support, satisfaction with parenting, parental involvement, communication, and limit setting. All hypotheses for research questions 1 and 2 were supported.

### **Research Question 1**

Parents reported significantly less discord in the parent-child relationship after their child attended residential treatment ( $M= 18.8$ ,  $SD= 10.4$ ) as compared to before entering treatment ( $M= 27.8$ ,  $SD=11.5$ ),  $t(102)= -7.142$ ,  $p < .001$ ,  $r^2= .11$ .

### **Research Question 2**

Parents reported significantly greater support from the treatment facility after their child attended residential treatment ( $M= 50.16$ ,  $SD= 9.80$ ) as compared to before entering treatment ( $M= 45.84$ ,  $SD= 8.55$ ),  $t(102)= 3.971$ ,  $p < .001$ ,  $r^2= .56$ . Additionally, parents reported significantly greater satisfaction with parenting after their child attended residential treatment ( $M= 49.7$ ,  $SD=8.3$ ) as compared to before entering treatment ( $M= 47.8$ ,  $SD= 9.8$ ),  $t(102)= 2.096$ ,  $p < .001$ ,  $r^2= .22$ . Parents reported significantly greater parental involvement with their children after their child attended

residential treatment ( $M= 45.1$ ,  $SD= 10.1$ ) as compared to before entering treatment ( $M=39.9$ ,  $SD=11.2$ ),  $t(102) = 4.458$ ,  $p < .001$ ,  $r^2 = .16$ . On average, parents reported significantly greater communication with their children after their child attended residential treatment ( $M= 43.0$ ,  $SD=7.4$ ) as compared to before entering treatment ( $M= 38.3$ ,  $SD=9.3$ ),  $t(102)= 4.809$ ,  $p < .001$ ,  $r^2 = .09$ . This indicates statistical significance and approaching a small effect. Further, parents reported significantly greater limit setting with their children after their child attended residential treatment ( $M= 48.2$ ,  $SD=6.5$ ) as compared to before entering treatment ( $M= 42.1$ ,  $SD=6.2$ ),  $t(102) = 9.002$ ,  $p < .001$ ,  $r^2 = .17$ . This indicates statistical significance and a small effect size.

### Research Question 3

Several important findings emerged from the participants' responses to the research question: What is the essence of the experience for a parent to have a child in residential mental health treatment, and how do parents perceive it to be experienced within the parent-child relationship?

Three main themes from the experience parents had when having a child in residential treatment emerged: *Help for the Family*, *Parental Involvement*, and *Help for the Child*. The theme of *Help for the Family* contained three subthemes: *Parent-Child Relationships*, *Sibling Relationships*, and *Hope for the Future*. Also, the theme of *Parental Involvement* contained three subthemes: *Parent Support Group*, *Parenting Classes*, and *Relief from Fear*. Lastly, the theme of *Help for the Child* contained three subthemes: *Improvements in Interpersonal Relations*, *Peer Relationships*, and *Threat of Larger Consequences*.

Participants were hopeful for sustained positive outcomes for the families and children in the future, and were making changes to help that take place. Participant parents indicated most helpful parts of the residential programs for themselves were the parent support groups and the least helpful were parenting classes (possibly due to the material/relevance or ways in which it was presented). Parents also often experienced relief when their children were placed in residential treatment, due to the children's dangerous behaviors and the many failed attempts at getting them help. Participants noted improvements in their children's interactions with themselves, their siblings, and their peers. Participants also attributed children's changes in positive directions to something other than their treatment: the threat of harsher consequences. In summary, this qualitative portion of the research study revealed the overall experience of having a child in residential treatment was a positive one, with multiple benefits for the parents, child, and family as a whole. Specifically, the study revealed the parent-child relationship can be associated with many positive benefits of the residential treatment experience.

### **Discussion**

The results of the quantitative portion of the study indicated, through the tests of the hypotheses that there were significant changes on all scales. On average, parents were found to have the perceptions that after their child attended residential treatment, they had less discord in the parent-child relationship, they were more supported in parenting, they were more satisfied with parenting, they communicated more with their child, they were more involved with their child, and they set more limits as a parent as compared to before their child entered treatment.

Results from the quantitative portion of the study indicate parents have the perception that residential treatment may be an effective means of assisting them to communicate in more appropriate ways with their child, and to set more appropriate limits with their child. Results also indicated parents perceived their child's residential treatment to have provided them with support as a parent and to have enabled them to become more satisfied as a parent, thus, potentially enabling them to parent more effectively and/or improving the parent/child relationship. Results indicated parents perceived they became more involved with their children and aware of their children's needs, after their child's residential treatment, potentially enabling them to improve their parent-child relationship. Finally, quantitative results indicated parents perceived there to be less discord in the parent-child relationship after the child completed residential treatment, as compared to before the child entered treatment, indicating less potential for abuse and conflict in the parent-child relationship.

Results from the qualitative portion showed the essence of having a child in residential treatment was overall a positive one and a beneficial one. Results also indicated the child's residential treatment experience was associated with improvements in the parent-child relationship. The results of this study indicate this group of participants found the residential treatment of their children to be a helpful experience for their families, for themselves as parents, and for the children in treatment.

These findings indicate children's residential mental health treatment can be associated with parental perceptions of significantly positive changes in the parent-child relationship. This research helps to make the case for utilizing residential treatment as an

option for children when families are in crisis. This contributes to the literature examining the effectiveness of residential treatment for children.

These results also indicate that it would be useful for residential treatment centers to have a support group and additional means of support offered for parents. They indicate residential treatment centers may want to revisit the usefulness of material presented in parenting classes, types of children they discuss, or ways in which material is presented. The results also indicate the usefulness of the possibility of further consequences as a motivating factor for children in residential treatment. Treatment centers could consider building into their programs a tour of juvenile detention or an alternative school.

### **Limitations**

First, the study was limited because the data was gathered from only one residential facility, which limits the generalizability of the findings to other residential populations. The fact that the participants for the focus group interview were mainly Caucasian can serve to make this data less generalizable. Also, the evolution of the program could be considered a limitation of the study. The qualitative information was gathered in a time period of over a year, and the qualitative data was not gathered until six months later, allowing for program changes to have taken place. Little control over treatment fidelity, common limitations of focus groups, the potential research bias of qualitative research, and the use of an outside transcriptionist were limitations. This study was limited in that information was gathered on the parental perspective only, and the child's perspective was not examined. Examining the parent-child relationships and its associations with the child's residential mental health treatment from the child's



perspective, also, would have made the research study more complete. The format of the self-report questionnaire was an additional limitation of the study. The researcher only gained information through what the parent was willing to report in the questionnaire. Limitations were also present with the instruments used in the study. The PCRI was normalized on predominantly white parents, and the IPA is targeted for use by those who have lived in western culture.

Internal validity threats were controlled for to the extent that it was possible in a study using already existing data. One validity threat was attrition. Not every family was able to complete the study because not all children that started the residential program completed it. Some parents refused to take the tests upon discharge. Maturation was another internal validity threat. Participants in this study completed the instruments first during their child's admission to treatment, and again during their child's discharge from treatment three months later. The participants may have changed during these three months between measurements. An additional validity threat was that the researcher was employed as a clinician at the residential facility in which the data was collected. This could have biased the study. However, since the study utilized data that had already been collected, this bias was minimized. Treatment fidelity was also a validity threat in this study. The researcher could not be certain how faithfully the treatment program intervention was carried out at the residential treatment center. Finally, repeated testing was an internal validity threat. The parents took the same test when the children entered treatment that they took when the children discharged from treatment. They may have become familiar with the questions. External validity threats were a risk in this study as

the researcher had little control over the internal factors in the study. By using existing data for the qualitative research, there was no chance of controlling inside the study.

### **Directions for Future Research**

Children's mental health, the parent-child relationship, and residential treatment are all areas that need more research literature to be fully understood. The findings from this research study imply that residential mental health treatment can be helpful for families and imply parents do perceive their parent-child relationship as changing in the positive direction after treatment. The finding that parent support groups were a very helpful part of the treatment program for the parents is an interesting finding that emerged from this study and could be considered for future research. Further research on the value of parent support groups or a more in depth study of parent support groups for those with children in residential treatment would be beneficial. Another interesting finding that emerged from the study was the parents starting to notice the siblings' problems in the home once the other child left for residential treatment. This also could be considered for future research. Research on how one child in the family going into residential treatment impact siblings would also be useful.

Another quantitative study that would further our understanding of children's residential mental health treatment would be a study focused on multiple residential facilities. For example, a future researcher may choose to gather data similar to data gathered in this study, from three local area residential facilities for children. Including multiple residential facilities would increase generalizability. Researchers could compare the results at the different residential centers and determine if they were getting similar results at each residential center, thus meaning the results were generalizable.

Further research needs to be conducted in this area to further determine the relationship of residential treatment and the parent-child relationship. There are many avenues for future research that stem from this research study. A quantitative study that would further our understanding of the parent-child relationship and its relationship to residential mental health treatment would be to replicate this study from the child's perspective. Future research can build upon this research and utilize instruments designed for use by children to examine their perceptions of the parent-child relationship. Ideally, a study would examine the relationship from both the parent and the child perspective. Examining the relationship from the perspective of all parties involved would make the research study more complete.

The limitations of this research study point to directions for future research. To further explore the association between the child's residential mental health treatment and the parent-child relationship, a mixed methods study designed to include parent-child interaction observations, and interviews with the families' mental health clinicians, in addition to the self-report questionnaires could be conducted. This would enable a more complete picture of the parent-child relationship to be gathered. This work leaves open the opportunity for future research and a continued refinement of residential mental health treatment for children and its associations with the parent-child relationship.

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## APPENDIX A

**Table 1****Demographic Characteristics of Archived Files*****Frequency Distribution by Gender of Participants' Children in Residential Treatment***

Gender	Frequency	Percent
Male	54	77.1%
Female	16	22.9%
Total	<i>N</i> = 70	100.0%

***Frequency Distribution by Ages of Participants' Children in Residential Treatment***

Ages	Frequency	Percent
Age 5	03	04.3%
Age 6	08	11.4%
Age 7	09	12.9%
Age 8	13	18.6%
Age 9	08	11.4%
Age 10	06	08.6%
Age 11	10	14.3%
Age 12	09	12.9%
Age 13	04	05.7%
Total	<i>N</i> = 70	100.0%

***Frequency Distribution by Ethnicity of Participants' Children in Residential Treatment***

Ethnicity	Frequency	Percent
Caucasian	40	57.1%
African American	19	27.1%
Biracial	07	10.0%
Hispanic	02	02.9%
Asian	01	01.4%
German	01	01.4%
Total	<i>N</i> = 70	100.0%

***Frequency Distribution by Family Income of Participants***

Income Level	Frequency	Percent
Low Income	19	27.1%
Medium Income	18	25.7%
High Income	11	15.7%
None Reported	22	31.4%
Total	<i>N</i> = 70	100.0%

***Frequency Distribution by Number of Siblings in the Home of the Participants' Child in Residential Treatment***

Number of Siblings	Frequency	Percent
None	17	24.3%
One	29	41.4%
Two	16	22.9%
Three	04	05.7%
Four	04	05.7%
Total	<i>N</i> = 45	100.0%

***Frequency Distribution by Participants' Partner Relationship Status***

Relationship Descriptor	Frequency	Percent
No Romantic Relationship	20	19.4%
Stable Romantic Relationship	58	56.3%
Unstable Romantic Relationship	25	24.3%
Total	<i>N</i> = 103	100.0%

***Frequency Distribution by Admission Diagnoses of the Participants' Children in Residential Treatment***

Diagnosis	Frequency	Percent
Attention Deficit Hyperactivity Disorder	40	34.5%
Oppositional Defiant Disorder	17	14.7%
Mood Disorder	35	30.2%
Post Traumatic Stress Disorder	05	04.3%
Asperger's Disorder	09	07.8%
Anxiety Disorder	04	03.4%
Other	06	05.2%
Total	<i>N</i> = 116	100.0%

***Frequency Distribution by Number of Admission Diagnoses of Participants' Children in Residential Treatment***

Number	Frequency	Percent
One	21	30.0%
Two	27	38.6%
Three	20	28.6%
Four or more	02	02.9%
Total	<i>N</i> = 70	100.0%

***Frequency Distribution by Residential Treatment History of Participants' Children***

Residential Treatment	Frequency	Percent
None	67	95.7%
One	03	04.3%
Two	00	00.0%
Three	00	00.0%

Four or more	00	00.0%
Total	<i>N</i> = 70	100.0%

***Frequency Distribution by Psychiatric Hospital Treatment History of Participants' Children in Residential Treatment***

Psychiatric Hospitalizations	Frequency	Percent
No admissions	61	87.1%
One admission	06	08.6%
Two admissions	01	01.4%
Three admissions	02	02.9%
Four or more admissions	00	00.0%
Total	<i>N</i> = 70	100.0%

***Frequency Distribution by Outpatient Treatment History of Participants' Children in Residential Care***

Number of Treatments	Frequency	Percent
None	22	31.4%
One	22	31.4%
Two	19	27.1%
Three	03	04.3%
Four or more	04	05.7%
Total	<i>N</i> = 70	100.0%

***Frequency Distribution by Outpatient Treatment History of Participants' Children in Residential Care***

Number of Treatments	Frequency	Percent
None	22	31.4%
One	22	31.4%
Two	19	27.1%
Three	03	04.3%
Four or more	04	05.7%
Total	<i>N</i> = 70	100.0%

Table 2

*Descriptive Statistics for the IPA and PCRI*

<b>IPA</b>	<b># Items</b>	<b>Range of Scores</b>	<b>Mean</b>	<b>SD</b>
Pre-Treatment	25	4.6-57.3	27.8	11.5
Post-Treatment	25	3.3-57.0	18.8	10.4
<b>PCRI Parental Support Scale</b>				
Pre-Treatment		25-70	45.8	8.5
Post-Treatment		19-74	50.2	9.8
<b>PCRI Satisfaction with Parenting Scale</b>				
Pre-Treatment	10	23-68	47.8	9.8
Post-Treatment	10	24-68	49.7	8.3
<b>PCRI Communication Scale</b>				
Pre-Treatment	9	10-60	38.3	9.3
Post-Treatment	9	24-62	43.0	7.4
<b>PCRI Involvement Scale</b>				

Pre-Treatment	14	15-65	39.9	11.2
Post-Treatment	14	18-72	45.1	10.1

**PCRI Limit Setting Scale**

Pre-Treatment	12	26-72	42.1	6.2
Post-Treatment	12	29-74	48.2	6.5

*Note.* IPA= Index of Parental Attitudes, PCRI = Parent Child Relationship Inventory

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## APPENDICES

Appendix A: Approval For Exempt Research

Appendix B: Consent Form

Appendix C: Agency Permission to Use Archival Data Letter

Appendix D: Demographics Sheet

Appendix E: Focus Group Interview Protocol



## APPENDIX A

## Approval for Exempt Research

Dr. Hays

Your proposal submission titled, “**The Association between Parental Perceptions of Children’s Residential Mental Health Treatment and the Parent Child Relationship**” has been deemed EXEMPT by the Human Subjects Review Committee of the Darden College of Education. If any changes occur, especially methodological, notify the Chair of the DCOE HSRC, and supply any required agenda requested of you by the Chair. You may begin your research once the committee receives a signed copy of your ODU Exempt Application. **Please send a signed hardcopy of your application submission to the address below.** Thank you.

Edwin Gomez, Ph.D.  
Associate Professor  
Chair, Human Subjects Review Committee, DCOE  
Recreation and Tourism Studies, ESPER  
Old Dominion University  
2010 Student Recreation Center  
Norfolk, VA 23529-0196

## APPENDIX B

### Consent Form

#### **Title of Research Study**

Parental Perceptions of Residential Mental Health Treatment

#### **Project Director**

The project director for this research study is Susanne E. Preston, LPC, Doctoral Candidate, Department of Counseling and Human Services, Old Dominion University, Norfolk, VA 23529. Telephone: (757) 553-1099. Email address: sknis001@odu.edu.

The project director is under the supervision of Dr. Danica Hays, Counseling Graduate Program Director, Department of Counseling and Human Services, Old Dominion University, Norfolk, VA 23529. Telephone: (757) 683- 6692. Email address: dhays@odu.edu.

#### **Purpose of the Research**

The purpose of this study is to explore the experience of parental perceptions of the parent-child relationship when parents have a child in residential mental health treatment. More specifically, the study will examine how residential treatment may be associated with specific aspects of the parent child relationship.

#### **Procedures for the Research**

Participants will voluntarily participate in a focus group interview. Questions will be asked regarding children's residential treatment and the parent-child relationship. This will take place face-to-face and will last approximately 90 minutes. The interview will

be audio taped and then transcribed for data analysis. No identifying information will be included in the transcript. The audiotapes will then be destroyed for confidentiality purposes.

**Potential Risks of Discomforts**

Due to the nature of this research, there are no identifiable risks to participants. Any concerns you might have about the disclosure of personal, family information related to the topic of study may be explored with the project director before the study, or at any other time. All aspects of participation are voluntary, and participants may choose to withdraw from the group interview at any time. Should a study participant feel uncomfortable as a result of participation in the study, he or she may contact the program director for assistance.

**Potential Benefits to You or Others**

The results of this research could be used to improve the residential mental health treatment of children, since this research will contribute to an understanding of how residential treatment is associated with the parent-child relationship.

**Alternative Procedures**

Individual interviews would be an alternative to the focus group interview format. However, they were not chosen for this study because a group interview format should provide more depth of information. Your participation is voluntary, and you may withdraw consent and terminate your participation in the study at any time, without any consequences.

**Protection of Confidentiality**

Your name and your child's name will be kept confidential at all times. Pseudonyms will be given to the participants when the audiotapes are transcribed, so your identity will not be used at any time. All audiotapes will be erased after transcription. The signed consent forms, group interview audiotapes, transcripts of the interview, and any other materials related to the study will be maintained in a secured and confidential lockbox by the project director. However, the project director cannot control the other focus group participants outside of the group setting. Although they will be asked to maintain confidentiality, it cannot be guaranteed that other group participants will respect your confidentiality.

### **Voluntary Participation**

Your participation in this study is completely voluntary. You have the right to withdraw from this study at any time without any penalty. Throughout the group interview, you have the right to answer or not answer any question that is asked. Even if you decide to participate and then change your mind, you may withdraw from the study and any comments you made will not be used. If you want to withdraw from the study, let the program director know at any time.

### **Signatures**

**I have been fully informed of the above described procedure with its possible risks and benefits. I have given my permission for participation in this study.**

\_\_\_\_\_  
**Participant's Signatures**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Participant's Name (Print)**

\_\_\_\_\_  
**Project Director's Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Project Director's Name (Print)**

## APPENDIX C

CITY OF VIRGINIA BEACHVBgov.comDEPARTMENT OF HUMAN SERVICESPENDLETON CHILD SERVICE CENTER(757) 385-4537FAX: (757) 385-45332473 NORTH LANDING ROADVIRGINIA BEACH, VIRGINIA 23456

June 20, 2009

To whom it may concern:

This letter is to confirm that the following data: Parent Child Relationship Inventory and Index of Parental Attitudes, is collected regularly on the clients that we serve as a part of their treatment plans. I give permission for Susanne E. Preston, LPC to use the data for a research study at Old Dominion University.

Sincerely,

Susan Dye, Ph.D.

Administrator

Appendix D  
Demographics Sheet

Client ID Number: \_\_\_\_\_

Age: \_\_\_\_\_

Gender:

1. Male
2. Female

Ethnicity

1. African American
2. Caucasian
3. Asian American
4. German
5. Hispanic
6. Biracial/Multicultural
7. Other \_\_\_\_\_

Number of Diagnoses:

1. None
2. One
3. Two
4. Three
5. Four or more

Number of Siblings in Household:

1. None
2. One
3. Two
4. Three
5. Four or more

Admission Diagnosis: (circle all)

1. ADHD
2. ODD
3. Mood disorder/ depression/bipolar
4. Aspergers/Autism
5. PTSD
6. Anxiety
7. Other \_\_\_\_\_

Household Income Level:

• \_\_\_\_\_

Parent romantic/intimate relationship status:

1. Not in a relationship
2. In a mostly stable relationship
3. In a strained/unstable relationship

Treatment History:

Number of previous admissions to residential treatment:

1. None
2. One
3. Two
4. Three
5. Four or More

Number of previous admissions to psychiatric hospitals:

1. None
2. One
3. Two
4. Three
5. Four or More

Number of previous attempts at out-client counseling:

1. None
2. One
3. Two
4. Three
5. Four or More

## Appendix E

### Focus Group Interview Protocol

1. What has your experience been with residential treatment at this facility?
2. What behaviors did you noticed in your child before placement in residential treatment?
3. What behaviors have you noticed in your child after he or she was placed in residential treatment?
4. What have you noticed about your relationship with your child since he or she has been in residential treatment?
5. How has, if at all, residential treatment been helpful to your family?
6. How has, if at all, residential treatment not been helpful to your family?
7. Do you attribute any noticeable changes in your family to things other than the treatment at the residential facility?
8. What recommendations, if any, do you have for future services at this residential facility?



## VITA

Susanne Elizabeth Preston earned a Bachelor's of Science degree in Psychology in 1999 from Virginia Polytechnic Institute and State University and a Master's of Science degree in Counseling Psychology from Chaminade University of Honolulu in 2002. She is a National Certified Counselor, a Registered Play Therapist Supervisor, a Distance Credentialed Counselor, and a Licensed Professional Counselor.

Ms. Preston specializes in counseling children and families and has worked as a school counselor and as a mental health clinician for multiple non-profit and city agencies. She is currently employed in private practice. Ms. Preston has 9 years of experience working in the counseling field. Ms. Preston has completed practicum/internship experiences in teaching graduate counseling students and clinical supervision of graduate counseling students.

Ms. Preston is an active member of several professional organizations including the American Counseling Association (ACA), the Association for Play Therapy (APT), and Association for Counselor Education and Supervision (ACES). At the state level, she is an active member of the Virginia Counseling Association (VCA), and the Virginia branch of the Association for Play Therapy. Additional professional affiliations include the Southern Association for Counselor Education and Supervision (SACES), and the Association for Creativity in Counseling. Ms. Preston is a member of Psi Chi, and the Delta Omega chapter of Chi Sigma Iota (CSI), national academic honor societies for psychology and counseling, respectively. Ms. Preston has also published several articles in university, city, and professional organization newsletters.